

Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.4

Submitted by:

Delaware Health and Social Services

Submission Date:	8-31-07
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CMS Receipt Date (CMS Use)	
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Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Description:
This is a request for a new Acquired Brain Injury Waiver for the State of Delaware.

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Effective Date	12-1-07

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.

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1. Request Information

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. **Waiver Title** (*optional*): Acquired Brain Injury Waiver

C. **Type of Request** (*select only one*):

<input checked="" type="checkbox"/>	New Waiver (3 Years)	CMS-Assigned Waiver Number (<i>CMS Use</i>):	
<input type="checkbox"/>	New Waiver (3 Years) to Replace Waiver #		
	CMS-Assigned Waiver Number (<i>CMS Use</i>):		
	<i>Attachment #1 contains the transition plan to the new waiver.</i>		
<input type="checkbox"/>	Renewal (5 Years) of Waiver #		
<input type="checkbox"/>	Amendment to Waiver #		

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

<input type="checkbox"/>	Model Waiver. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
<input checked="" type="checkbox"/>	Regular Waiver , as provided in 42 CFR §441.305(a)

E.1 **Proposed Effective Date:** 12-1-07

E.2 **Approved Effective Date** (*CMS Use*):

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*):

<input type="checkbox"/>	Hospital (<i>select applicable level of care</i>)
<input type="checkbox"/>	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:
<input type="checkbox"/>	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
<input checked="" type="checkbox"/>	Nursing Facility (<i>select applicable level of care</i>)
<input checked="" type="checkbox"/>	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:
<input type="checkbox"/>	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
<input type="checkbox"/>	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 facility level of care:

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

<input type="checkbox"/>	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I		
<input type="checkbox"/>	Waiver(s) authorized under §1915(b) of the Act. <i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i>		
Specify the §1915(b) authorities under which this program operates (<i>check each that applies</i>):			
<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)	<input type="checkbox"/>	§1915(b)(3) (employ cost savings to furnish additional services)
<input type="checkbox"/>	§1915(b)(2) (central broker)	<input type="checkbox"/>	§1915(b)(4) (selective contracting/limit number of providers)
<input type="checkbox"/>	A program authorized under §1115 of the Act. <i>Specify the program:</i>		
<input checked="" type="checkbox"/>	Not applicable		

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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

This waiver provides for services for individuals aged 18 and above who have sustained an acquired brain injury (ABI) and who would otherwise require care in a nursing facility.

Goals and objectives

The goal of the waiver is to provide services to persons with ABI in a manner which responds to each consumer's abilities, assessed needs, and preferences, and which ensures maximum consumer self-sufficiency, independent functioning, and safety. This goal will be accomplished through the delivery of a range of home and community-based long-term care services, including assisted living, which target the special needs of the ABI population.

Organizational structure

The Acquired Brain Injury Waiver will be administered by the Division of Medicaid and Medical Assistance (DMMA), the State Medicaid agency, and operated by the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD). Both agencies are located organizationally within Delaware Health and Social Services (DHSS).

Operationally, DSAAPD and DMMA will share responsibilities for determining eligibility for waiver program applicants. Initial medical eligibility determinations will be conducted by DSAAPD. However, DSAAPD will accept long term care medical eligibility determinations performed by DMMA for Acquired Brain Injury Waiver medical eligibility. DMMA will determine financial eligibility for applicants. DMMA will sign service agreements with case management providers referred by DSAAPD to provide care planning, ongoing case management and follow-up for all participants enrolled in the waiver program. DSAAPD will monitor the case management providers, and will carry out other activities within the approved DMMA quality assurance and improvement framework and plan. Ultimately, DMMA will retain authority for oversight of all waiver program operations by assuring that DSAAPD monitors the services provided to the ABI participants.

DSAAPD will work in coordination 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 Health and Social Services. DSAAPD houses Delaware's Long Term Care Ombudsman Program (LTCOP), which investigates non-abuse-related complaints in assisted living and other long term care facilities, as well as 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. The active participation of DLTCRP, LTCOP, and APS will form an important component of the quality assurance and quality improvement systems of the Acquired Brain Injury Waiver.

Service delivery methods

The Acquired Brain Injury Waiver will include home and community-based services provided on a statewide basis by agencies contracted by DMMA at the direction and request of DSAAPD. Case managers will work with participants to develop care plans in which independence and individual decision-making are maximized. Services will be provided according to each individual's preferences and capabilities. At the same time, service contractors and state agencies will 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.

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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*):

<input type="radio"/>	The waiver provides for participant direction of services. <i>Appendix E is required.</i>
<input checked="" type="checkbox"/>	Not applicable. The waiver does not provide for participant direction of services. <i>Appendix E is not completed.</i>

- 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 Management Strategy.** Appendix H contains the Quality Management 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*):

<input type="radio"/>	Yes
<input checked="" type="checkbox"/>	No
<input type="radio"/>	Not applicable

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

<input type="radio"/>	Yes (<i>complete remainder of item</i>)
<input checked="" type="checkbox"/>	No

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

<input type="checkbox"/>	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. <i>Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:</i>
<input type="checkbox"/>	Limited Implementation of Participant-Direction. A waiver of statewideness is requested in order to make <i>participant direction of services</i> 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. <i>Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:</i>

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**.

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- 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 Improvement Act of 2004 (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) under age 21 when 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 amount, frequency and duration 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

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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 §431.51, 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 Management.** 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 Management 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 implement an ABI Waiver will be placed in the Delaware Register of Regulations on October 1, 2007, 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

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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 as 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:

First Name:	Nancy
Last Name	Kling
Title:	Administrator
Agency:	Division of Medicaid and Medical Assistance
Address 1:	1901 N. DuPont Highway
Address 2:	Lewis Building
City	New Castle
State	DE
Zip Code	19720
Telephone:	302-255-9625
E-mail	nancy.kling@state.de.us
Fax Number	(302) 255-4481

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

First Name:	Lisa
Last Name	Bond
Title:	Planning Supervisor
Agency:	Division of Services for Aging and Adults with Physical Disabilities
Address 1:	1901 N. DuPont Highway
Address 2	Administration Building Annex
City	New Castle
State	DE
Zip Code	19720
Telephone:	302-255-9390
E-mail	lisa.bond@state.de.us
Fax Number	302-255-4445

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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: _____ **Date:** _____
 State Medicaid Director or Designee

First Name:	Harry
Last Name	Hill
Title:	Director
Agency:	Division of Medicaid and Medical Assistance
Address 1:	1901 N. DuPont Highway
Address 2:	Lewis Building
City	New Castle
State	DE
Zip Code	19720
Telephone:	302-255-9627
E-mail	Harry.hill@state.de.us
Fax Number	(302) 255-4481

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Appendix A: Waiver Administration and Operation

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

<input type="radio"/>	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 (<i>select one; do not complete Item A-2</i>):	
<input type="radio"/>	The Medical Assistance Unit (<i>name of unit</i>):	
<input type="radio"/>	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (<i>name of division/unit</i>)	
<input checked="" type="checkbox"/>	The waiver is operated by	Division of Services for Aging and Adults with Physical Disabilities (DSAAPD)
	a separate agency of the State that is not a division/unit of the Medicaid agency. 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. <i>Complete item A-2.</i>	

2. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, 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:

Delaware Health and Social Services (DHSS) is the state agency with overall accountability for Delaware's public health and social service programs. DHSS's Division of Medicaid and Medical Assistance (DMMA) is directly responsible for either the operation or oversight of all Medicaid funded programs (e.g., Managed Care, Waivers). DHSS's Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) is responsible for the operation of the Acquired Brain Injury Waiver.

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

DMMA will conduct monitoring of the operation of the Acquired Brain Injury Waiver program on at least a quarterly basis. This includes, but is not limited to the review of DSAAPD's subcontractor and provider audits/oversight reviews; quality assurance program data; policies and procedures; records; provider recruitment efforts; and number of approved waiver enrollment limits maintained by staff. Specifically, monitoring will occur 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 Service Delivery Unit.

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QII: DSAAPD Quality Improvement Committee (QIC) consisting of the Senior Operations Administrator, the Long-Term Care Ombudsman, the Adult Protective Services Administrator, the Case Manager Administrator and the Nurse Consultants will meet monthly to discuss quality performance measures, devise quality improvement initiatives, and resolve concerns and complaints. Issues relevant to performance measures will be reported quarterly by the QIC to DMMA through the QII. DMMA, as the oversight agency, will play the central role in the operation of the QII. Additional details about this process can be found in Appendix H.

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.

On a quarterly basis, the SUR subsystem, also operated by DMMA, 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 auditor 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 that are conducted and has the ability to compile trends data that result in the initiation of continued or new reviews. (See Appendix H.)

DMMA Service Delivery Unit: DMMA’s Service Delivery Unit will conduct an annual retrospective review of 25% of ABI care plans. The ABI care plan review will consist of a desk audit to ensure completion in accordance with all applicable ABI policies and procedures. DSAAPD will submit to DMMA a quarterly report documenting the findings of the ongoing review of ABI care plans, periodic compliance audits, and resulting corrective action plans. These reports will be submitted to DMMA through the QII, as described in the Quality Management Strategy in Appendix H. (See also Appendix D-1-g.)

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

<input checked="" type="checkbox"/>	<p>Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. <i>Complete Items A-5 and A-6.</i></p>
	<p>Delaware will utilize two types of outside entities to perform operational and administrative functions under this waiver: 1) case managers; and 2) provider relations agent. The specific roles of each entity are listed in Question # 7 of this section and are summarized below. Services agreements/contracts will be signed by the DMMA Director or designee.</p> <p><u>Case managers</u> As described in Appendix C, case management will be provided as a service under this waiver through a Medicaid provider agreement. The state will enter into agreements with all willing,</p>

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Appendix A: Waiver Administration and Operation

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	<p>qualified providers of this service. Waiver participants will be afforded the opportunity to choose among case management providers. As part of the case management service, certain inherent administrative functions, will be performed. Such functions include: monitoring waiver expenditures against approved levels; reviewing participant service plans to ensure that waiver requirements are met; and performing prior authorization of services.</p> <p><u>Provider relations agent</u> Specific functions performed by the provider relations agent include: enrolling service providers at the direction of DSAAPD; executing the Medicaid provider agreement; conducting training and providing technical assistance to providers concerning waiver requirements; and verifying provider licensure on an annual basis.</p>
<p><input type="radio"/></p>	<p>No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).</p>

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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 (*check each that applies*):

<input type="checkbox"/>	<p>Local/Regional non-state public agencies conduct waiver operational and administrative functions at the local or regional level. There is an interagency agreement or memorandum of understanding between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these agencies and complete items A-5 and A-6:</i></p>
<input type="checkbox"/>	<p>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). <i>Specify the nature of these entities and complete items A-5 and A-6:</i></p>
<input checked="" type="checkbox"/>	<p>Not applicable – Local/regional non-state agencies do not perform waiver operational and administrative functions.</p>

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:

With input from DSAAPD, the Division of Medicaid and Medical Assistance (DMMA) is responsible for assessing the performance of the provider relations agent. The Division of Services for Aging and Adults with Physical Disabilities (DSAAPD), at the direction of DMMA, will monitor the work of the case management providers.

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:

Case management

DSAAPD, with guidance from DMMA, will monitor the work of case management providers. To carry out these monitoring responsibilities, DSAAPD nurses will review 100 percent of initial ABI care plans developed by case managers. In addition, case managers will provide DSAAPD with monthly reports detailing case management operations compliance measures (as described in Appendix H). The DSAAPD Waiver Coordinator will compile these reports for submission to the DSAAPD Quality Improvement Committee (QIC). Finally, the DSAAPD Waiver Coordinator will review prior authorization and service utilization reports from MMIS on a monthly basis, identifying trends and service improvement opportunities; information from these reports will also be compiled for review by the QIC. All of these findings will be reported quarterly to DMMA through the QII. These monitoring activities are described more fully in Appendix H.

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Provider relations agent

DMMA's MMIS Status Group, comprised of the Chief Administrators, fiscal staff, and contract monitors, reviews the provider relations agent's performance. This team meets with the provider relations agent account management team twice per month to review performance measures, and input from other agencies. 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 that all provider activities are reviewed and approved by DMMA.

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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.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Assist individuals in waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manage waiver enrollment against approved limits	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Monitor waiver expenditures against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Conduct level of care evaluation activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Review participant service plans to ensure that waiver requirements are met	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Perform prior authorization of waiver services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Conduct utilization management functions	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recruit providers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Execute the Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Determine waiver payment amounts or rates	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct training and technical assistance concerning waiver requirements	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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Appendix B: Participant Access and Eligibility

Appendix 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. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup 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:*

SELECT ONE WAIVER TARGET GROUP	TARGET GROUP/SUBGROUP	MINIMUM AGE	MAXIMUM AGE	
			MAXIMUM AGE LIMIT: THROUGH AGE –	NO MAXIMUM AGE LIMIT
<input checked="" type="checkbox"/>	Aged or Disabled, or Both (<i>select one</i>)			
<input type="checkbox"/>	Aged or Disabled or Both – General (<i>check each that applies</i>)			
	<input type="checkbox"/>	Aged (age 65 and older)		
	<input type="checkbox"/>	Disabled (Physical) (under age 65)		
	<input type="checkbox"/>	Disabled (Other) (under age 65)		
<input checked="" type="checkbox"/>	Specific Recognized Subgroups (<i>check each that applies</i>)			
	<input checked="" type="checkbox"/>	Brain Injury	18	<input checked="" type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS		<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile		<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent		<input type="checkbox"/>
<input type="checkbox"/>	Mental Retardation or Developmental Disability, or Both (<i>check each that applies</i>)			
	<input type="checkbox"/>	Autism		<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability		<input type="checkbox"/>
	<input type="checkbox"/>	Mental Retardation		<input type="checkbox"/>
<input type="checkbox"/>	Mental Illness (<i>check each that applies</i>)			
	<input type="checkbox"/>	Mental Illness (age 18 and older)		<input type="checkbox"/>
	<input type="checkbox"/>	Serious Emotional Disturbance (under age 18)		

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

ABI waiver services are limited to individuals with an Acquired Brain Injury (ABI). An ABI is an injury to the brain which is not hereditary, congenital, degenerative, or induced by birth trauma. Individuals must meet nursing facility level of care standards established by the State's preadmission screening process, be at least 18 years of age, and also meet the following criteria:

1. Diagnosis of an acquired brain injury (Diagnosis based on ICD-9 Codes developed by the Center for Disease Control and Prevention – reviewed and updated by Delaware Medicaid medical consultants on a periodic basis)
2. Exhibit medical, emotional, behavioral, and/or cognitive deficits resulting from their brain

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- injury; and
3. Have a rating of at least 5 but no greater than 8 on the Rancho Los Amigos Level of Cognitive Functioning Scale.

The purpose of these ABI waiver services is to provide community supports to individuals (adults 18 years of age or older) with physical, cognitive and/or behavioral symptoms, which require supervised and/or supportive care. The ABI Care Plan for participants in the ABI waiver must demonstrate that the ABI waiver participant would benefit from ABI case management and at least one other ABI waiver services (Level II Enhanced ABI Adult Day Services, Cognitive Services, Day Habilitation, Level II Enhanced ABI Assisted Living) that are not available in another waiver.

In the absence of meeting the definition above, these are examples of congenital and degenerative diseases that would be excluded:

<u>Congenital Development Problems</u>	<u>Progressive Processes/Diseases</u>
Cerebral Palsy	Alzheimer’s Disease
Autism	Dementing Processes
Developmental Delay	Amyotrophic Lateral Sclerosis (ALS)
Down’s Syndrome	Multiple Sclerosis (MS)
Spina Bifida with Hydrocephalus	Parkinson’s Disease and similar movement disorders
Muscular Dystrophy	Huntington’s Disease

This definition is intended to include ABIs attributable to the following: anoxia; hypoxia; aneurysm and vascular malformations; brain tumors; encephalitis, meningitis, metabolic encephalopathies; stroke with cognitive disabilities; diffuse axonal injury; concussion; contusion, coup-contrecoup injury; second impact syndrome (recurrent TBI); and penetration injury.

- 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*):

<input checked="" type="checkbox"/>	Not applicable – There is no maximum age limit
<input type="checkbox"/>	The following transition planning procedures are employed for participants who will reach the waiver’s maximum age limit (<i>specify</i>):

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Appendix B-2: Individual Cost Limit

- 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*):

<input checked="" type="checkbox"/>	No Cost Limit. The State does not apply an individual cost limit. <i>Do not complete Item B-2-b or Item B-2-c.</i>		
<input type="checkbox"/>	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. <i>Complete Items B-2-b and B-2-c.</i> The limit specified by the State is (<i>select one</i>):		
<input type="checkbox"/>		%, a level higher than 100% of the institutional average	
<input type="checkbox"/>	Other (<i>specify</i>):		
<input type="checkbox"/>			
<input type="checkbox"/>	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. <i>Complete Items B-2-b and B-2-c.</i>		
<input type="checkbox"/>	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. <i>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.</i>		
<input type="checkbox"/>			
<input type="checkbox"/>	The cost limit specified by the State is (<i>select one</i>):		
<input type="checkbox"/>	The following dollar amount: \$		
<input type="checkbox"/>	The dollar amount (<i>select one</i>):		
<input type="checkbox"/>	Is adjusted each year that the waiver is in effect by applying the following formula:		
<input type="checkbox"/>	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.		
<input type="checkbox"/>	The following percentage that is less than 100% of the institutional average:		%
<input type="checkbox"/>	Other – <i>Specify</i> :		
<input type="checkbox"/>			

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- 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:

NA

- 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*):

<input type="checkbox"/>	The participant is referred to another waiver that can accommodate the individual’s needs.
<input type="checkbox"/>	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:
<input type="checkbox"/>	Other safeguard(s) (<i>specify</i>):

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Appendix B-3: Number of Individuals Served

- 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	50
Year 2	60
Year 3	70
Year 4 (renewal only)	
Year 5 (renewal only)	

- 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)*:

<input checked="" type="checkbox"/>	The State does not limit the number of participants that it serves at any point in time during a waiver year.
<input type="checkbox"/>	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)	

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- 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*):

<input checked="" type="checkbox"/>	Not applicable. The state does not reserve capacity.	
<input type="checkbox"/>	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:	
	The capacity that the State reserves in each waiver year is specified in the following table:	
	Table B-3-c	
	Purpose:	Purpose:
Waiver Year	Capacity Reserved	Capacity Reserved
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

- 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*):

<input checked="" type="checkbox"/>	The waiver is not subject to a phase-in or a phase-out schedule.
<input type="checkbox"/>	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 <i>intra-year</i> limitation on the number of participants who are served in the waiver.

- e. Allocation of Waiver Capacity.** *Select one:*

<input checked="" type="checkbox"/>	Waiver capacity is allocated/managed on a statewide basis.
<input type="checkbox"/>	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:

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

Entry to the ABI Medicaid Waiver is offered to all eligible persons. However, should the ABI Waiver reach capacity, a waiting list will be developed. Criteria for the waiting list will be as follows: First priority will be given to individuals who are already approved and enrolled in the Elderly & Disabled Medicaid Waiver (E & D) or the Assisted Living (AL) Medicaid Waiver Programs. Individuals will be placed on the ABI Waiting List according to the date determined ABI medically eligible. Second priority will be given to individuals not enrolled in DSAAPD E & D Medicaid or AL Medicaid Waivers. These individuals will be placed on the ABI Waiting List according to the date determined ABI medically and financially eligible.

Individuals on the waiting list for the ABI Waiver will be assessed to see if they are eligible for services under Title III, the Social Services Block Grant (SSBG) or state funds. These services may include adult day services, assistive devices, attendant services, case management, emergency response system, housekeeping, personal care and respite care. If the individual is opened in a Medicaid program they will receive Medicaid State Plan services while on the waiting list for the ABI Waiver.

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Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

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

<input checked="" type="checkbox"/>	§1634 State
<input type="checkbox"/>	SSI Criteria State
<input type="checkbox"/>	209(b) State

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:*

<i>Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)</i>	
<input type="checkbox"/>	Low income families with children as provided in §1931 of the Act
<input checked="" type="checkbox"/>	SSI recipients
<input type="checkbox"/>	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
<input checked="" type="checkbox"/>	Optional State supplement recipients
<input type="checkbox"/>	Optional categorically needy aged and/or disabled individuals who have income at: (<i>select one</i>)
<input type="checkbox"/>	100% of the Federal poverty level (FPL)
<input type="checkbox"/>	% of FPL, which is lower than 100% of FPL
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
<input type="checkbox"/>	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)
<input type="checkbox"/>	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)
<input type="checkbox"/>	Medically needy
<input type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify:</i>
<i>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</i>	
<input type="checkbox"/>	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.
<input checked="" type="checkbox"/>	Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. <i>Select one and complete Appendix B-5.</i>
<input type="checkbox"/>	All individuals in the special home and community-based waiver group under 42 CFR §435.217

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<input checked="" type="checkbox"/>	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 (<i>check each that applies</i>):		
<input checked="" type="checkbox"/>	A special income level equal to (select one):		
<input type="checkbox"/>		300% of the SSI Federal Benefit Rate (FBR)	
<input checked="" type="checkbox"/>	250 %	of FBR, which is lower than 300% (42 CFR §435.236)	
<input type="checkbox"/>	\$	which is lower than 300%	
<input type="checkbox"/>	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)		
<input type="checkbox"/>	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)		
<input type="checkbox"/>	Medically needy without spend down in 209(b) States (42 CFR §435.330)		
<input type="checkbox"/>	Aged and disabled individuals who have income at: (<i>select one</i>)		
<input type="checkbox"/>	<input type="checkbox"/>	100% of FPL	
<input type="checkbox"/>	<input type="checkbox"/>	%	of FPL, which is lower than 100%
<input type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify</i> :		

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Appendix B-5: Post-Eligibility Treatment of Income

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*):

<input checked="" type="checkbox"/>	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 (<i>select one</i>):
<input checked="" type="checkbox"/>	Use <i>spousal</i> post-eligibility rules under §1924 of the Act. <i>Complete Items B-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.</i>
<input type="checkbox"/>	Use <i>regular</i> post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (<i>Complete Item B-5-b-1</i>) or under §435.735 (209b State) (<i>Complete Item B-5-c-1</i>). <i>Do not complete Item B-5-d.</i>
<input type="checkbox"/>	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. <i>Complete Item B-5-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.</i>

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1. Regular Post-Eligibility Treatment of Income: SSI State and §1634 State. The State uses the post-eligibility rules at 42 CFR §435.726. 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 (<i>select one</i>):	
<input type="checkbox"/>	The following standard included under the State plan (<i>select one</i>):
<input type="checkbox"/>	SSI standard
<input type="checkbox"/>	Optional State supplement standard
<input type="checkbox"/>	Medically needy income standard
<input type="checkbox"/>	The special income level for institutionalized persons (<i>select one</i>):
<input type="checkbox"/>	300% of the SSI Federal Benefit Rate (FBR)
<input type="checkbox"/>	% of the FBR, which is less than 300%
<input type="checkbox"/>	\$ which is less than 300%.
<input type="checkbox"/>	% of the Federal poverty level
<input type="checkbox"/>	Other (specify):
<input type="checkbox"/>	

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<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:		
ii. Allowance for the spouse only (select one):			
<input type="radio"/>	SSI standard		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Not applicable (<i>see instructions</i>)		
iii. Allowance for the family (select one):			
<input type="radio"/>	AFDC need standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following 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.
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Other (specify):		
<input type="radio"/>	Not applicable (<i>see instructions</i>)		
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. <i>Select one:</i>			
<input type="radio"/>	Not applicable (<i>see instructions</i>)		
<input type="radio"/>	The State does not establish reasonable limits.		
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>):		

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c-1. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant’s income:

i. Allowance for the needs of the waiver participant (<i>select one</i>):			
<input type="radio"/>	The following standard included under the State plan (<i>select one</i>)		
<input type="radio"/>	The following standard under 42 CFR §435.121:		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The special income level for institutionalized persons (<i>select one</i>)		
<input type="radio"/>		300% of the SSI Federal Benefit Rate (FBR)	
<input type="radio"/>	%		of the FBR, which is less than 300%
<input type="radio"/>	\$		which is less than 300% of the FBR
<input type="radio"/>	%		of the Federal poverty level
<input type="radio"/>	Other (specify):		
<input type="radio"/>	The following dollar amount: \$ _____ If this amount changes, this item will be revised.		
<input type="radio"/>	The following formula is used to determine the needs allowance:		
ii. Allowance for the spouse only (<i>select one</i>):			
<input type="radio"/>	The following standard under 42 CFR §435.121		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount: \$ _____ If this amount changes, this item will be revised.		
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Not applicable (<i>see instructions</i>)		
iii. Allowance for the family (<i>select one</i>):			
<input type="radio"/>	AFDC need standard		
<input type="radio"/>	Medically needy income standard		

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<input type="radio"/>	The following 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.
<input type="radio"/>	The amount is determined using the following formula: <div style="border: 1px solid black; height: 20px; width: 100%; background-color: #f0f0f0;"></div>
<input type="radio"/>	Other (specify): <div style="border: 1px solid black; height: 20px; width: 100%; background-color: #f0f0f0;"></div>
<input type="radio"/>	Not applicable (<i>see instructions</i>)
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:	
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. <i>Select one:</i>	
<input type="radio"/>	Not applicable (<i>see instructions</i>)
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>): <div style="border: 1px solid black; height: 20px; width: 100%; background-color: #f0f0f0;"></div>

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NOTE: Items B-5-c-2 and B-5-d-2 are for use by states that use spousal impoverishment eligibility rules and elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State and §1634 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 <i>(select one):</i>		
<input type="radio"/>	The following standard included under the State plan <i>(select one)</i>	
	<input type="radio"/>	SSI standard
	<input type="radio"/>	Optional State supplement standard
	<input type="radio"/>	Medically needy income standard
	<input type="radio"/>	The special income level for institutionalized persons <i>(select one):</i>
	<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)
	<input type="radio"/>	% of the FBR, which is less than 300%
	<input type="radio"/>	\$ which is less than 300%.
	<input type="radio"/>	% of the Federal poverty level
	<input type="radio"/>	Other (specify):
<input type="radio"/>	The following dollar amount:	\$ If this amount changes, this item will be revised.
<input checked="" type="checkbox"/>	The following formula is used to determine the needs allowance:	
	The needs allowance is an amount equal to the SSI Federal Benefit Rate plus an amount equal to the Optional State Supplement for individuals living in Adult Foster Care Homes. All other persons who reside in the community based settings will have a needs allowance equal to 250% of the FBR.	
ii. Allowance for the spouse only <i>(select one):</i>		
<input type="radio"/>	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 the amount of the allowance:	
	<input type="radio"/>	SSI standard
	<input type="radio"/>	Optional State supplement standard
	<input type="radio"/>	Medically needy income standard
	<input type="radio"/>	The following dollar amount: \$ If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	

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<input checked="" type="checkbox"/>	Not applicable (<i>see instructions</i>)	
iii. Allowance for the family (<i>select one</i>):		
<input checked="" type="checkbox"/>	AFDC need standard	
<input type="checkbox"/>	Medically needy income standard	
<input type="checkbox"/>	The following dollar amount: \$ <input style="width: 50px;" type="text"/> 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.	
<input type="checkbox"/>	The amount is determined using the following formula: <input style="width: 100%; height: 20px;" type="text"/>	
<input type="checkbox"/>	Other (<i>specify</i>): <input style="width: 100%; height: 20px;" type="text"/>	
<input type="checkbox"/>	Not applicable (<i>see instructions</i>)	
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. <i>Select one:</i>		
<input type="checkbox"/>	Not applicable (<i>see instructions</i>)	
<input checked="" type="checkbox"/>	The State does not establish reasonable limits.	
<input type="checkbox"/>	The State establishes the following reasonable limits (<i>specify</i>): <input style="width: 100%; height: 20px;" type="text"/>	

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 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 amounts and expenses from the waiver participant’s income:

i. Allowance for the needs of the waiver participant (<i>select one</i>):		
<input type="checkbox"/>	The following standard included under the State plan (<i>select one</i>)	
<input type="checkbox"/>	The following standard under 42 CFR §435.121: <input style="width: 100%; height: 20px;" type="text"/>	
<input type="checkbox"/>	Optional State supplement standard	
<input type="checkbox"/>	Medically needy income standard	

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<input type="radio"/>	The special income level for institutionalized persons (<i>select one</i>)		
	<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
	<input type="radio"/>	%	of the FBR, which is less than 300%
	<input type="radio"/>	\$	which is less than 300% of the FBR
	<input type="radio"/>	%	of the Federal poverty level
<input type="radio"/>	Other (specify):		
<input type="radio"/>			
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:		
<input type="radio"/>			
ii. Allowance for the spouse only (<i>select one</i>):			
<input type="radio"/>	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:		
<input type="radio"/>			
<input type="radio"/>	Specify the amount of the allowance:		
<input type="radio"/>	The following standard under 42 CFR §435.121:		
<input type="radio"/>			
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>			
<input type="radio"/>	Not applicable (<i>see instructions</i>)		
iii. Allowance for the family (<i>select one</i>):			
<input type="radio"/>	AFDC need standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following 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.
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>			

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<input type="radio"/>	Other (specify):
<input type="radio"/>	Not applicable (<i>see instructions</i>)
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:	
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. <i>Select one:</i>	
<input type="radio"/>	Not applicable (<i>see instructions</i>)
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>):

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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, a family allowance, and an amount for incurred expenses for medical or remedial care.

i. Allowance for the personal needs of the waiver participant (<i>select one</i>):		
<input type="radio"/>	SSI Standard	
<input type="radio"/>	Optional State Supplement standard	
<input type="radio"/>	Medically Needy Income Standard	
<input type="radio"/>	The special income level for institutionalized persons	
<input type="radio"/>	%	of the Federal Poverty Level
<input type="radio"/>	The following dollar amount: \$	If this amount changes, this item will be revised
<input checked="" type="checkbox"/>	The following formula is used to determine the needs allowance: The needs allowance is an amount equal to the SSI Federal Benefit Rate plus an amount equal to the Optional State Supplement for individuals living in Adult Foster Care Homes. All other persons who are in community-based settings will have a personal needs allowance equal to 250% of the Federal Benefit Rate.	
<input type="radio"/>	Other (<i>specify</i>):	
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. <i>Select one:</i>		
<input checked="" type="checkbox"/>	Allowance is the same	
<input type="radio"/>	Allowance is different. Explanation of difference:	
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:		
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. <i>Select one:</i>		
<input type="radio"/>	Not applicable (<i>see instructions</i>)	
<input checked="" type="checkbox"/>	The State does not establish reasonable limits.	
<input type="radio"/>	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.	

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Appendix 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 waiver 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 (<i>insert number</i>):
	2
ii.	Frequency of services. The State requires (<i>select one</i>):
<input checked="" type="checkbox"/>	The provision of waiver services at least monthly
<input type="checkbox"/>	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*):

<input type="checkbox"/>	Directly by the Medicaid agency
<input type="checkbox"/>	By the operating agency specified in Appendix A
<input type="checkbox"/>	By an entity under contract with the Medicaid agency. <i>Specify the entity</i> :
<input checked="" type="checkbox"/>	Other (<i>specify</i>):
	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), the Medicaid agency, for initial requests for nursing facility services for the ABI Waiver. 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.

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- 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 Acquired Brain Injury Waiver program. This comprehensive 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 mental 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*):

<input checked="" type="checkbox"/>	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
<input type="checkbox"/>	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 Acquired Brain Injury Medicaid Waiver services in Delaware. DSAAPD Community Services Program (CSP) staff interview potential waiver participants within 5 days of their referral to perform an initial screening to determine interest and potential eligibility for the waiver including whether the person’s condition requires a nursing facility level of care determination and meets the additional eligibility criteria for the ABI Waiver.

If the participant is already receiving Medicaid, CSP staff will refer 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).

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If Medicaid 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 completes and approves the Level of Care Instrument, described in B-6 (e).

The evaluation and reevaluation of a level of care is 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*):

<input type="radio"/>	Every three months
<input type="radio"/>	Every six months
<input checked="" type="checkbox"/>	Every twelve months
<input type="radio"/>	Other schedule (<i>specify</i>):

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

<input checked="" type="checkbox"/>	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
<input type="radio"/>	The qualifications are different. The qualifications of individuals who perform reevaluations are (<i>specify</i>):

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

The Tracking Assessment and Planning (TAP) system, DSAAPD’s Long-Term Care monitoring system application includes tracking capabilities for Level of Care evaluations and re-evaluations for both DSAAPD screening and nursing staff.

TAP will provide staff with “review due” schedules. It also furnishes monitoring reports to DSAAPD leadership including the status of Level of Care re-determinations including timely completion of all required LOC re-determination tasks. Data will be available both on an individual and state wide basis to support these monitoring strategies.

In addition to performance monitoring, TAP has rules built into the process to ensure that participants meet financial and technical eligibility standards at opening and upon each review.

- 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 §74.53. 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.

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Appendix 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).

The CSP staff members performing the initial waiver screenings are responsible for informing potential waiver participants or representatives about freedom of choice by discussing the Medicaid Waiver Home and Community-based programs and the alternative option of institutional care in the initial interview. 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 choice which confirms that participants and/or their legal guardian or representative understand and request choice of home and community -based services or institutional care.

If a participant chooses the Acquired Brain Injury Waiver Program, an additional Awareness Form is signed. This form describes the program, services available, individual responsibilities, and presents information about freedom of choice. The form is reviewed and signed by the participant and/or their legal guardian or representative and CSP staff member. A copy of the form is given to the participant and/or their legal guardian or representative. A copy is also maintained in the DSAAPD case file.

These forms will be signed by the Acquired Brain Injury Waiver participants annually when their choices are reaffirmed during DSAAPD nursing re-determination visits.

- b. **Maintenance of Forms.** Per 45 CFR §74.53, 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 individual's case file folder located in the DSAAPD offices.

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Appendix B-8: Access to Services by Limited English Proficient 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 ABI Waiver. CSP staff utilizes the following resources to support Waiver eligibles and participants with interpretation: AT & T Language Line and independently-contracted language interpreters.

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Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *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:*

Statutory Services (<i>check each that applies</i>)		
Service	Included	Alternate Service Title (if any)
Case Management	<input checked="" type="checkbox"/>	
Homemaker	<input type="checkbox"/>	
Home Health Aide	<input type="checkbox"/>	
Personal Care	<input checked="" type="checkbox"/>	
Adult Day Health	<input checked="" type="checkbox"/>	Adult Day Services
Habilitation	<input type="checkbox"/>	
Residential Habilitation	<input type="checkbox"/>	
Day Habilitation	<input checked="" type="checkbox"/>	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	<input type="checkbox"/>	
Supported Employment	<input type="checkbox"/>	
Education	<input type="checkbox"/>	
Respite	<input checked="" type="checkbox"/>	
Day Treatment	<input checked="" type="checkbox"/>	Cognitive Services
Partial Hospitalization	<input type="checkbox"/>	
Psychosocial Rehabilitation	<input type="checkbox"/>	
Clinic Services	<input type="checkbox"/>	
Live-in Caregiver (42 CFR §441.303(f)(8))	<input type="checkbox"/>	
Other Services (<i>select one</i>)		
<input type="radio"/>	Not applicable	
<input checked="" type="checkbox"/>	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute (<i>list each service by title</i>):	
a.	Personal Emergency Response System	
b.	Assisted Living	

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c.	
d.	
e.	
f.	
g.	
h.	
i.	

Extended State Plan Services (select one)

<input checked="" type="checkbox"/>	Not applicable
<input type="checkbox"/>	The following extended State plan services are provided (<i>list each extended State plan service by service title</i>):
a.	
b.	
c.	

Supports for Participant Direction (select one)

<input type="checkbox"/>	The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
<input checked="" type="checkbox"/>	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	<input type="checkbox"/>	
Financial Management Services	<input type="checkbox"/>	

Other Supports for Participant Direction (*list each support by service title*):

a.	
b.	
c.	

b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a covered waiver service, indicate how case management is furnished to waiver participants (*check each that applies*):

<input type="checkbox"/>	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). <i>Complete item C-1-c.</i>
<input type="checkbox"/>	As an administrative activity. <i>Complete item C-1-c.</i>
<input type="checkbox"/>	Not applicable – Case management is not furnished as a distinct activity to waiver participants. <i>Do not complete Item C-1-c.</i>

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

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Appendix C-2: General Service Specifications

- 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):

<input checked="" type="checkbox"/>	<p>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):</p> <p>Applicants for employment in Home Health Agencies (Personal Care Services and Respite Services) will be required by State Statute (DE Code 16, 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 in an assisted living 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. Civil penalties, denial of facility payment and/or facility closure may be invoked for infractions of this law.</p> <p>Applicants for employment in Adult Day Services will be required by State Statute (DE Code 16, 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 in an assisted living 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. Civil penalties, denial of facility payment and/or facility closure may be invoked for infractions of this law.</p> <p>Applicants for employment in licensed facilities including Assisted Living will be required to perform state and federal criminal history and/or background investigations. Applicant refers to any person seeking employment in an assisted living 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 assisted living 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.</p> <p>Each assisted living 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</p>
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	<p>from state and federal authorities. DLTCRP then sends the assisted living facility a letter with the results of the investigation. The assisted living 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.</p> <p>Electronic Data Systems (EDS) is a contracted entity with the State of Delaware that verifies the licensure status at the time of provider application.</p>
<input type="radio"/>	No. Criminal history and/or background investigations are not required.

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*):

<input checked="" type="checkbox"/>	<p>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):</p> <p>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 that 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, and Assisted Living 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.)</p>
<input type="radio"/>	No. The State does not conduct abuse registry screening.

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

<input type="radio"/>	No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. <i>Do not complete Items C-2-c.i – c.iii.</i>
<input checked="" type="checkbox"/>	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>Complete Items C-2-c.i –c.iii.</i>

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
Assisted Living	Assisted Living	Limit set by State Licensing Entity

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		Division of Long Term Care Residents Protection
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- 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 Assisted Living the goal is to provide services to adults (age 18 and older) with ABI in a manner which responds to each consumer’s abilities, assessed needs, and preferences, and which ensures maximum consumer self-sufficiency, independent functioning and safety in a “homelike” residential setting. This homelike environment has the qualities of a home including privacy, comfortable surroundings supported by the use of furnishings, and the opportunity to modify one’s living area to suit one’s individual preferences. A homelike environment provides consumers 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 consumer’s wishes and needs, as identified by a standardized assessment instrument; and a philosophy of care that emphasizes consumer independence, choice, privacy and dignity. (Note that the Waiver does not provide reimbursement for room and board. The consumer pays for room and board costs.) Delaware assisted living facilities provide supportive and health services based on a social model of care rather than on an institutional medical care model. If requested or needed the provider must provide assistance to coordinate transportation to medical appointments and recreational activities as well as beauty/barber services. A maximum of two residents is allowed per resident unit and each sharing resident is guaranteed 80 square feet of floor space. Residents may modify one’s living area to suit one’s preferences. Residents may bring in personal possessions and decorate their room area as long as it does not offend the rights of another resident. Each living unit is separate and distinct from each other. The provider must ensure that each individual living unit is equipped with a lockable door. Residents may lock their unit unless it is a violation of fire code or their physician has documented this action to be a danger. Bathroom facilities shall be available to residents either in their individual living units or in an area readily accessible to each resident. There shall be at least one working toilet, sink and tub/shower for every four residents. Resident kitchens must be available in the individual unit or in an area readily accessible to each resident. Residents shall have access to a microwave or stove/conventional oven, refrigerator and sink. Congregate dining is available to residents. Private living room areas and common areas are available for residents to entertain family and friends. The provider must also ensure the availability of private space, upon request for residents to use for meetings of consumer based groups or resident councils. The provider must designate a smoking policy that ensures that consumers who do smoke have a designated area and consumers who do not smoke are not subject to second-hand smoke. Providers who choose to be smoke-free must provide this information upfront to prospective consumers.

- iii. Scope of Facility Standards.** By type of facility listed in Item C-2-c-i, specify whether the State’s standards address the following (*check each that applies*):

Standard	Facility Type	Facility Type	Facility Type	Facility Type
	Assisted Living			
Admission policies	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Safety	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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:

- 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:*

<input checked="" type="radio"/>	No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
<input type="radio"/>	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 <i>extraordinary care</i> 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. <i>Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.</i>

- 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:*

<input checked="" type="radio"/>	The State does not make payment to relatives/legal guardians for furnishing waiver services.
<input type="radio"/>	The State makes payment to relatives/legal guardians under <i>specific circumstances</i> 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

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	to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.</i>
<input type="radio"/>	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-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.</i>
<input type="radio"/>	Other policy. <i>Specify:</i>

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The State’s contracted provider relations agent for Medicaid services provides prospective Acquired Brain Injury (ABI) providers access to a comprehensive Delaware Medical Assistance Program (DMAP) web site. This web site provides detailed information about the Medicaid ABI 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. Acquired Brain Injury 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 ABI Medicaid waiver provider. DSAAPD has it own web site and toll-free phone line available for general information.

DSAAPD will then begin the pre-qualification process through contact with the DSAAPD Waiver Coordinator. This position will offer to inform the prospective provider agency to the following required documentation to begin the pre-qualifying process.

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.

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. ABI Waiver provider applicants will also need the following specific documentation according to their category of enrollment:

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Category	Requirements
Adult Day Services Provider	Business License/ 501 (c)(3) status Delaware Adult Day Care Facility License
Assisted Living Provider	Business License/ 501 (c)(3) status Delaware Long Term Care Facility License
Case Management Provider	Business License/ 501 (c)(3) status Licensed RN Licensed Clinical Social Worker
Day Habilitation Provider	Business License/ 501 (c)(3) status
Cognitive Services Provider	Business License/ 501 (c)(3) status State Applicable Provider license for at least one of the following: physician, neuro-psychologist, LCSW, RN or family counselor
Emergency Response System Provider	Business License/ 501 (c)(3) status
Personal Care Provider	Business License/ 501 (c)(3) status Delaware Home Health Agency License
Respite Care Provider	Business License/ 501 (c)(3) status Delaware Home Health Agency License

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 ABI 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 ABI Waiver services.

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Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification			
Service Title:	Case Management		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>Services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is granted. Services include identifying, planning, educating, accessing, monitoring and coordinating all community-based supports and services.</p> <p>As part of the case management service, certain inherent administrative functions, will be performed. Such functions include: monitoring waiver expenditures against approved levels; reviewing participant service plans to ensure that waiver requirements are met; and performing prior authorization of services.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
None			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
		Licensed Registered Nurse (RN)	Case Management Agency: Licensed Registered Nurse (RN) or Licensed Clinical Social Worker (LCSW)
		Licensed Clinical Social Worker (LCSW)	
Specify whether the service may be provided by <i>(check each that applies):</i>		<input type="checkbox"/> Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individual	State Business license / Licensed RN per Delaware Code, Title 24, Chapter 19 of the Professional Regulation / LCSW	N/A	N/A

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	per <u>Delaware Code</u> , Title 24, Chapter 39 of the Professional Regulation		
Agency	State Business license and staff must be licensed RNs per <u>Delaware Code</u> , Title 24, Chapter 19 of the Professional Regulation or LCSWs per <u>Delaware Code</u> , Title 24, Chapter 39 of the Professional Regulation	N/A	N/A
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Individual	Division of Services for Aging and Adults with Physical Disabilities; Division of Medicaid and Medical Assistance (through EDS – a provider relations agent contractor)	Annual	
Agency	Division of Services for Aging and Adults with Physical Disabilities; Division of Medicaid and Medical Assistance (through EDS – a provider relations agent contractor)	Annual	
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Service Specification			
Service Title:	Assisted Living		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>Assisted Living services are divided into the following two (2) levels of service and associated reimbursements:</p> <p><u>Level I or Basic Assisted Living</u> encompasses personal care and supportive services (homemaker, chore, attendant services, and meal preparation) that are furnished to waiver participants who reside in a homelike, non-institutional setting that includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming, and medication assistance (to the extent permitted under State law). Services that are provided by third parties must be coordinated with the assisted living provider.</p> <p><u>Level II or Enhanced ABI Assisted Living</u> is intended to provide a supplemental service rate or additional reimbursement for psycho-social Assisted Living services that are beyond the scope of Level I or Basic Assisted Living in the State of Delaware. This reimbursement level exists in recognition of the fact that some participants with ABI will require more attention because of the nature of their injuries. At this level, an example of additional attention may include prompting to carry out desired behaviors and/or to curtail inappropriate behaviors. In the care planning process, case managers will coordinate with assisted living service providers to determine appropriate care needs and reimbursement levels.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
None.			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>
			Agency. List the types of agencies:
			Assisted Living
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
			Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>

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Assisted Living	State Business license and Delaware Assisted Living License as noted in Delaware Regulations for Assisted Living Agencies, Title 16, Part II, Chapter 11, <u>Delaware Code</u>	N/A	N/A
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Assisted Living	Division of Services for Aging and Adults with Physical Disabilities; Division of Medicaid and Medical Assistance (through EDS – a provider relations agent contractor); Division of Long Term Care Resident Protection	Annually	
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Service Specification	
Service Title:	Adult Day Services
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>Adult Day Services are divided into the following two (2) levels of service and associated reimbursements:</p> <ul style="list-style-type: none"> <u>Level I or Basic Adult Day Services (aka Adult Day Care)</u> encompasses both health and social services needed to ensure the optimal functioning of the participant. Services are generally furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). <u>Level II or Enhanced ABI Adult Day Services</u> is intended to provide a Supplemental Service Rate or additional reimbursement for the additional staff time needed to care for participants who demonstrate ongoing behavioral patterns and/or ADL dependencies which increase the amount of staff time needed to care for those participants. The behavior and need for intervention must occur at least weekly, and be documented as such. <p>Note: The ABI Adult Day Programming strategy includes the two levels of Adult Day Services and the Day Habilitation Service. In most cases these services are delivered by the same or similar providers. Case managers will integrate (as appropriate) these three options to ensure accomplishment of desired outcomes in the most cost effective manner.</p>	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
<p>Limit of no more than four (4) days per week of either or combined levels of service or day habilitation. Case managers prior authorize all waiver services including service request exceptions above these limits.</p> <p>Exceptions to the limits on waiver services are reviewed and if appropriate, granted on a case by case basis. These requests are reviewed by the case manager in consultation with the DSAAPD nursing staff and waiver participant's provider. The following is a description of this process:</p> <ul style="list-style-type: none"> The case management care plan is utilized to assess what progress against goals and objectives have been made in regard to the request; The case manager will interview the provider and waiver participant to assess the ongoing needs of the client and the benefit to be gained by the increase in waiver service; The case manager will review their research findings with the state nurse and make a decision as to the request and its benefit to the waiver participant; and The case manager will collaborate with the provider and waiver client to either increase services at an appropriate level or explore other alternatives that may provide similar benefits to the waiver participant; and The case manager will modify the care plan to monitor the new service utilization against updated goals and objectives. 	
Provider Specifications	
Provider Category(s)	<input type="checkbox"/> Individual. List types: <input checked="" type="checkbox"/> Agency. List the types of agencies:
	Adult Day Care Facility

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<i>(check one or both):</i>			
Specify whether the service may be provided by <i>(check each that applies):</i>		<input type="checkbox"/> Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Adult Day Service	State Business license and Delaware Adult Day Care Facility License as noted in <u>Delaware Code Title 16-4402 Regulations for Adult Day Care Facilities.</u>	N/A	N/A
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Adult Day Service	Division of Services for Aging and Adults with Physical Disabilities; Division of Medicaid and Medical Assistance (through EDS – a provider relations agent contractor); Department of Health and Social Services	Annually	
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Service Specification			
Service Title:	Day Habilitation		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>Day Habilitation service is the assistance with the acquisition, retention, or improvement in self-help, socialization and adaptive skills that take place in a non-residential setting separate from the participant’s private residence or other residential living arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Meals provided as part of these services shall not constitute a “full nutritional regiment” (3 meals per day). Day habilitation services focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the service plan. In addition, day habilitation services may serve to reinforce skills or lessons taught in other settings. Transportation between the participant’s residence and the day habilitation site is provided as a component part of day habilitation services and the cost of transportation is included in the rate paid to providers.</p> <p>Note: The ABI Adult Day Programming strategy includes the two levels of Adult Day Services and the Day Habilitation Service. In most cases these services are delivered by the same or similar providers. Case managers will integrate (as appropriate) these three options to ensure accomplishment of desired outcomes in the most cost effective manner.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Limit of no more than four (4) days per week either independently, or in combination with Adult Day Services. Case managers prior authorize all ABI waiver services including service request exceptions above these limits.			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>
			Agency. List the types of agencies:
			Adult Day Care Facility
			Day Habilitation Facility (non-residential)
Specify whether the service may be provided by <i>(check each that applies)</i> :	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
		Relative/Legal Guardian	
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Adult Day Care	State Business license and Delaware Adult Day Care Facility License as noted in <u>Delaware Code Title 16-</u>	N/A	N/A

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	4402 Regulations for Adult Day Care Facilities.		
Day Habilitation	State Business license	N/A	N/A
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Adult Day Care	Division of Services for Aging and Adults with Physical Disabilities; Division of Medicaid and Medical Assistance (through EDS – a provider relations agent contractor); Department of Health and Social Services		Annually
Day Habilitation	Division of Services for Aging and Adults with Physical Disabilities; Division of Medicaid and Medical Assistance (through EDS – a provider relations agent contractor).		Annually
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Service Specification	
Service Title:	Cognitive Services
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>Cognitive Services are necessary for the diagnosis and treatment of individuals who exhibit cognitive deficits or interpersonal conflict resulting from brain injury. Cognitive Services include two key components with different levels of reimbursement:</p> <ul style="list-style-type: none"> • <u>Multidisciplinary Assessment</u> and consultation to determine the participant’s level of functioning and service needs. This Cognitive Services component includes neuropsychological consultation and assessments, functional assessment and the development and implementation of a structured behavioral intervention plan. • <u>Behavioral Therapies</u> include remediation, programming, counseling and therapeutic services for participants and their families which have the goal of decreasing or modifying the participant’s significant maladaptive behaviors or cognitive disorders that are not covered under the Medicaid State Plan. These services consist of the following elements: Individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law.), services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness, individual activity therapies that are not primarily recreational or diversionary, family counseling (the primary purpose of which treatment of the individual’s condition) and diagnostic services. The purpose of this service is to maintain the individual’s condition and functional level and to prevent relapse or hospitalization. 	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
<p>Limit of up to twenty (20) visits per year plus assessment. Case managers prior authorize all ABI waiver services including service request exceptions above these limits.</p> <p>Exceptions to the limits on waiver services are reviewed and if appropriate, granted on a case by case basis. These requests are reviewed by the case manager in consultation with the DSAAPD nursing staff and waiver participant’s provider. The following is a description of this process:</p> <ul style="list-style-type: none"> ▪ The case management care plan is utilized to assess what progress against goals and objectives have been made in regard to the request; ▪ The case manager will interview the provider and waiver participant to assess the ongoing needs of the client and the benefit to be gained by the increase in waiver service; ▪ The case manager will review their research findings with the state nurse and make a decision as to the request and its benefit to the waiver participant; and ▪ The case manager will collaborate with the provider and waiver client to either increase services at an appropriate level or explore other alternatives that may provide similar benefits to the waiver participant; and ▪ The case manager will modify the care plan to monitor the new service utilization against updated goals and objectives. 	
Provider Specifications	
Provider Category(s)	<input checked="" type="checkbox"/> Individual. List types: <input checked="" type="checkbox"/> Agency. List the types of agencies:

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<i>(check one or both):</i>	Neuropsychologist	ABI Outpatient Program with provider types as identified under Behavioral Therapies above.		
	Other Behavioral Health/Counseling Providers – Identified Under Behavioral Therapies Above			
Specify whether the service may be provided by <i>(check each that applies)</i> :	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>				
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>	
Cognitive Services	State Business license	N/A	N/A	
Physician Psychologist Neuropsychologist Registered Nurse Licensed Clinical Social Worker Family Counselor	State Applicable Provider license	N/A	N/A	
Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Cognitive Services	Division of Services for Aging and Adults with Physical Disabilities; Division of Medicaid and Medical Assistance (through EDS – a provider relations agent contractor).		Annually	
Neuropsychologists & Other Behavioral Health/Counseling Providers	Division of Services for Aging and Adults with Physical Disabilities; Division of Medicaid and Medical Assistance (through EDS – a provider relations agent contractor).		Annually	
Service Delivery Method				
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

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Service Specification				
Service Title:	Personal Care Services			
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>				
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.			
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.			
<input type="radio"/>	Service is not included in the approved waiver.			
Service Definition (Scope):				
A range of assistance to enable waiver participants who live in the community (outside AL facilities) to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cueing to prompt the participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis. Health-related services that are provided may include skilled or nursing care and medication administration to the extent permitted by State law.				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
Limit of up to fourteen (14) hours per week. Case managers prior authorize all ABI waiver services including service request exceptions above these limits.				
Provider Specifications				
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:	
			Home Health Agency	
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>				
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>	
Home Health Agency	State Business license and State Home Health Agency License Form 1539 from Office of Health Facilities Licensing and Certification per <u>Delaware Code Title 16-4406 Home Health Agencies (Licensure)</u>	N/A	N/A	
Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:	Frequency of Verification		
Home Health Agency	Division of Services for Aging and Adults with Physical Disabilities; Division of Medicaid and	Annually		

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	Medical Assistance (through EDS – a provider relations agent contractor); Division of Public Health			
Service Delivery Method				
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

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Service Specification			
Service Title:	Respite Care Services		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
Respite Care Services are provided to Waiver participants who live in the community (outside AL facilities), who are unable to care for themselves. In home respite care is furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Limit of up to eighty (80) hours per waiver year. Case managers prior authorize all ABI waiver services including service request exceptions above these limits.			
<p>Exceptions to the limits on waiver services are reviewed and if appropriate, granted on a case by case basis. These requests are reviewed by the case manager in consultation with the DSAAPD nursing staff and waiver participant's provider. The following is a description of this process:</p> <ul style="list-style-type: none"> ▪ The case management care plan is utilized to assess what progress against goals and objectives have been made in regard to the request; ▪ The case manager will interview the provider and waiver participant to assess the ongoing needs of the client and the benefit to be gained by the increase in waiver service; ▪ The case manager will review their research findings with the state nurse and make a decision as to the request and its benefit to the waiver participant; and ▪ The case manager will collaborate with the provider and waiver client to either increase services at an appropriate level or explore other alternatives that may provide similar benefits to the waiver participant; and ▪ The case manager will modify the care plan to monitor the new service utilization against updated goals and objectives. 			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
			Home Health Agency
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Home Health Agency	State Business license and State Home Health Agency License	N/A	N/A

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	Form 1539 from Office of Health Facilities Licensing and Certification per Delaware Title 16-4406 Home Health Agencies (Licensure)		
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Home Health Agency	Division of Services for Aging and Adults with Physical Disabilities; Division of Medicaid and Medical Assistance (through EDS – a provider relations agent contractor); Division of Public Health	Annually	
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Service Specification			
Service Title:	Personal Emergency Response System (PERS)		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>Personal Emergency Response Systems (PERS) is an electronic device that enables waiver participants who live in the community (outside AL facilities) 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.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
<p>Limit of up to \$400.00 per waiver year. Case managers prior authorize all ABI waiver services including service request exceptions above these limits.</p> <p>Exceptions to the limits on waiver services are reviewed and if appropriate, granted on a case by case basis. These requests are reviewed by the case manager in consultation with the DSAAPD nursing staff and waiver participant’s provider. The following is a description of this process:</p> <ul style="list-style-type: none"> ▪ The case management care plan is utilized to assess what progress against goals and objectives have been made in regard to the request; ▪ The case manager will interview the provider and waiver participant to assess the ongoing needs of the client and the benefit to be gained by the increase in waiver service; ▪ The case manager will review their research findings with the state nurse and make a decision as to the request and its benefit to the waiver participant; and ▪ The case manager will collaborate with the provider and waiver client to either increase services at an appropriate level or explore other alternatives that may provide similar benefits to the waiver participant; and ▪ The case manager will modify the care plan to monitor the new service utilization against updated goals and objectives. 			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/> Individual. List types: Business Owner	<input checked="" type="checkbox"/> Agency. List the types of agencies: PERS agency	
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/> Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian	
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
PERS Agency	State Business license	N/A	N/A

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Business Owners	State Business license	N/A	N/A
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
PERS Agency	Division of Services for Aging and Adults with Physical Disabilities; Division of Medicaid and Medical Assistance (through EDS – a provider relations agent contractor).	Annually	
Business Owners	Division of Services for Aging and Adults with Physical Disabilities; Division of Medicaid and Medical Assistance (through EDS – a provider relations agent contractor).	Annually	
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*check each that applies*).

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; and, (f) how participants are notified of the amount of the limit.

<input type="checkbox"/>	<p>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. <i>Furnish the information specified above.</i></p>
<input type="checkbox"/>	<p>Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. <i>Furnish the information specified above.</i></p>
<input type="checkbox"/>	<p>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. <i>Furnish the information specified above.</i></p>
<input checked="" type="checkbox"/>	<p>Other Type of Limit. The State employs another type of limit. <i>Describe the limit and furnish the information specified above.</i></p> <p>The ABI Waiver will employ an aggregate cost cap on services, both waiver services and other services. The total costs for services supplied to all ABI Waiver clients in a month (expenditures accumulated by date of service) will be divided by the number of ABI waiver clients in that month. The costs will then be compared with the aggregate monthly cost cap.</p> <p>While there are limits on some individual services, there is no dollar limit on the “package” of wavier services provided to an individual waiver recipient. Therefore, there is no individual budget for recipients. DSAAPD’s waiver team has developed, as part of its overall quality management strategy described in Appendix H, reporting and monitoring indicators to allow for early identification of waiver services that may be reaching their budget limit or being over utilized. This information will then be utilized to assess the waiver providers to identify outliers that will then be met with in a collaborative manner to identify opportunities for improvement. In the event, that the higher than expected costs or utilization are occurring on a system wide basis, options for quality improvement or budget adjustments will be assessed on an ongoing basis.</p> <p>The aggregate monthly cost cap is based upon the estimated average total allowable Medicaid cost (nursing home costs state plan costs, etc) of a person “institutionalized” in an Intermediate Care Facility or a Skilled Nursing Facility (Taxonomy 314000000X or 313M00000X) at a Level of</p>

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Reimbursement score in the 10 thru 83 range, which excludes the special cases of MR, mental disease, and super skilled.

The monthly cap was set by taking the “Total Factor G and G Prime” value from Appendix J (\$79,423) and dividing that figure by the estimated number of days used in those calculations (350) to arrive at a per day cost of \$227. Using 30.4 as the average number of days in a month, the monthly cost cap was set at \$227 per day x 30.4 days = \$6,901 (rounded)

NOTE: For an explanation of how the Factor G and G Prime figures used in this cost cap calculation were compiled see Appendix J-2 Sections c iii and c iv. The same methodology was used to calculate the monthly cost cap for Year 2 and Year 3.

Summary of Cost Cap Calculations:

<u>Wvr Year</u>	<u>Sum of G & G Prime</u>		<u>Est # Days in Waiver</u>	=	<u>Cost Per Day</u>	x	<u>Avg Days in Month</u>	<u>Monthly Cost Cap</u>
1	\$79,423	/	350	=	\$226.92	x	30.4	\$6,898 (rounded)
2	\$81,965	/	350	=	\$234.19	x	30.4	\$7,119 (rounded)
3	\$84,915	/	350	=	\$242.62	x	30.4	\$7,376 (rounded)

Note: Although the ABI Waiver will utilize an aggregate cost cap, case managers and DSAAPD nurses will monitor and support individual waiver participants’ needs, utilization, and costs through:

- Care plan monitoring, review, and approval processes;
- Monthly monitoring and reporting of prior authorizations and actual utilization; and
- Coordination with community and other state programs to enhance service delivery to meet the individual waiver participants needs.

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

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Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	ABI Care Plan
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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 (*check each that applies*):

<input type="checkbox"/>	Registered nurse, licensed to practice in the State
<input type="checkbox"/>	Licensed practical or vocational nurse, acting within the scope of practice under State law
<input type="checkbox"/>	Licensed physician (M.D. or D.O)
<input checked="" type="checkbox"/>	Case Manager (qualifications specified in Appendix C-3)
<input type="checkbox"/>	Case Manager (qualifications not specified in Appendix C-3). <i>Specify qualifications:</i>
<input type="checkbox"/>	Social Worker. <i>Specify qualifications:</i>
<input type="checkbox"/>	Other (<i>specify the individuals and their qualifications</i>):

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

<input checked="" type="checkbox"/>	Entities and/or individuals that have responsibility for service plan development <i>may not provide</i> other direct waiver services to the participant.
<input type="checkbox"/>	Entities and/or individuals that have responsibility for service plan development <i>may provide</i> 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. <i>Specify:</i>

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) will furnish each participant and/or their 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 ABI care plan, the case

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manager will review the Awareness Form with the waiver participant and/or their legal guardian or representative.

(b) Participant's Authority

The participant has complete authority to bring to the service planning meeting(s) whomever he/she would like to include in the process. In fact, the participant will be actively encouraged to bring others, e.g., family members and/or other interested persons, to these meetings.

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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 ABI care plan development
 The individual participant is the central figure in the development of his/her ABI 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 ABI care plans. If, for whatever reason, a participant can not be present for the development of his/her ABI care plan, then his/her representative must be present.

Service providers may also participate in the ABI care plan development process, along with the case manager. ABI care plans must be developed and approved prior to or on the date of a participant’s receipt of services.

An ABI care plan is updated at least annually by the case manager. It is also reviewed at least annually during the level of care determination process initiated by the DSAAPD nurse. This re-determination process takes place through an in-person visit, as described in Appendix D-2 below. Also, revisions are made to ABI care plans more frequently, as needed. Revisions are triggered by changes in a participant’s service needs observed and documented by case managers during scheduled monitoring visits. (For more details about monitoring visits, see section D-2.)

(b) Assessments
 Initial screening for the ABI 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 will perform this level of care determination only in cases in which participant’s initial request is for nursing home services. See Appendix B-6.)

Follow-up assessments are also conducted prior to the ABI care plan process by case managers. 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. Additionally, for participants enrolling in assisted living, facilities collect and compile information on a participant’s conditions and needs through the use of a uniform assessment tool developed by the Division of Long Term Care Residents Protection, as required by Delaware’s assisted living regulations.

(c) Informing participants
 The case manager has principle responsibility for informing participants of services available under

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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
- ABI care plan negotiation
- Managed Risk Agreement (See the Risk Assessment and Mitigation description in section D-1.e below.)
- 18-Day non-medical leave policy
- Storage of personal belongings (for assisted living)
- 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 is the principal participant in the ABI care plan development process. He or she is encouraged to have family members or other interested persons present at the ABI care plan meeting to make sure that individual needs, preferences, and goals are communicated and understood. The ABI care plan form itself is designed to include narrative 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 service planning process. The ABI 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 Acquired Brain Injury Waiver are coordinated by the case manager. Each participant has a written ABI 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 ABI care plan also addresses routine health care, medications, transportation, EPSDT services and special needs covered under the Medicaid State Plan and notes who is responsible for providing this care. The case manager is responsible for following up to see that the participant's needs are met. For participants living in assisted living facilities, the case manager will coordinate with staff designated by the facility. The review/monitoring of the ABI 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 case manager is responsible for overseeing and monitoring the implementation of the ABI care plan. Specifically, case managers who are involved in the development and approval of an ABI care plan monitor and document its implementation. These case managers are also involved in the revision of ABI care plans, as needed.

(g) Plan updates

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The State does not make use of interim ABI care plans. However, follow-up visits are made by case managers on a scheduled basis and if, on the basis of these contacts it is evident that service needs have changed, individual ABI care plans are revised. Case managers are required to contact each participant in person monthly and update plans at least annually.

Case managers also respond to changes in participant conditions noted by other parties involved. Changes in condition are reported through the following processes:

- Service providers, including assisted living providers, report all significant changes in functional level to case managers
- DSAAPD nurses (following annual eligibility re-determination visits) report significant changes in functional level to case managers
- Family members, physicians and/or other interested persons report significant changes in functional level to case managers

Case managers make adjustments to ABI care plans, as needed, in response to these reported changes in participant conditions.

- 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 ABI care plan development process includes risk assessment and, on an as-needed basis, the development of a managed risk agreement. This process ensures that waiver participants make independent choices with an understanding of related risks.

For persons in assisted living facilities, this process takes place in response to Delaware state regulations. According to Delaware’s assisted living regulations, managed risk agreements may be developed to document an equal understanding between residents and facilities in cases where individual choice may present a risk to the resident. The regulations clearly state that the agreements: 1) cannot be used to restrict individual choice; and 2) do not release the facilities from liability. Under these regulations, managed risk agreements are not mandatory.

The regulations state:

The assisted living facility shall make no attempt to use the managed/negotiated risk portion of the service agreement to abridge a resident’s rights or to avoid liability for harm caused to a resident by the negligence of the assisted living facility and any such abridgement or disclaimer shall be void. (16 Del. C., Chapter 11, 3225.13.12).

Process

For participants in assisted living facilities as well as those living outside of facilities, risks are assessed during the initial participant assessment process and during the development of the ABI 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

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present identifiable risks, a managed risk agreement is incorporated into the ABI care plan.

The following are criteria for a managed risk agreement:

- The risks are tolerable to all parties participating in the development of the managed 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 managed risk agreement is made a part of the ABI care plan, it will:

- Clearly describe the problem, issue or service that is the subject of the managed 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, and any third parties;
- Become a part of the ABI care plan, be signed separately by the participant, the assisted living facility (if applicable) or other provider, and any other third party with obligations under the managed risk agreement; and
- Include a time frame for review.

Back-Up Plans

Back up plans become part of each ABI care plan.

Back-up plans for assisted living residents take the form of emergency plans at the facility level. State regulation requires assisted living facilities to inform residents about emergency back-up plans and to document any special needs of residents related to these plans. For example, back-up plans for physical emergencies, such as fires or other natural disasters, are required. Regulations also require facilities to make provisions for back-up staffing, as needed. For these residents, plans are in place at the individual level for back up services and supplies. Assisted living facilities maintain lists of alternate providers. In the event that a primary provider is unable to deliver the service/supply, a secondary provider is contacted.

For waiver participants not living in assisted living facilities, individual back-up plans will be in place for services included in the ABI care plan. Case managers will 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 will contact the back-up providers and schedule services as needed.

- 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 an ABI care plan, participants and/or their legal guardian or representative are provided with an Awareness Form which includes information about the freedom to choose among providers. Participants and/or their legal guardian or representative are

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also given a list of providers and can choose among these service providers. This list can be made available to a participant and/or their legal guardian or representative at any time during his/her enrollment in the waiver program.

- 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 State Medicaid agency, have a memorandum of understanding detailing roles and responsibilities under this waiver.

As part of this memorandum, the ABI care plan oversight responsibility of DMMA is delineated. Specifically, DMMA will be responsible for 1) overseeing DSAAPD’s review of the case manager’s care plans; and 2) for directly reviewing a sample of ABI care plans.

Oversight of operating agency review: DSAAPD nurses will review and approve all initial ABI care plans and will communicate these activities quarterly to DMMA through a report to the Quality Initiative Improvement (QII) Task Force. DMMA will review reports and follow up, as needed. This process is described more fully in Appendix H.

Direct review of care plans: DMMA will also review a 25% sample of ABI care plans annually. The DMMA ABI care plan review will consist of a desk audit of case files to ensure completion in accordance with all applicable policies and procedures. This sample size was derived based on the understanding that the process of direct review will supplement the 100 percent review by DSAAPD nurses and the substantial oversight activities on the part of DMMA through the QII Task Force.

- 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:*

<input type="radio"/>	Every three months or more frequently when necessary
<input type="radio"/>	Every six months or more frequently when necessary
<input checked="" type="checkbox"/>	Every twelve months or more frequently when necessary
<input type="radio"/>	Other schedule (<i>specify</i>):

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- 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 §74.53. Service plans are maintained by the following (*check each that applies*):

<input type="checkbox"/>	Medicaid agency
<input checked="" type="checkbox"/>	Operating agency
<input checked="" type="checkbox"/>	Case manager
<input type="checkbox"/>	Other (<i>specify</i>):

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Appendix 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) Case managers assigned to individual cases will be responsible for overseeing the implementation of ABI care plans and for participants' health and welfare. As described in Appendix H, reporting and monitoring indicators will be integrated into participant monitoring tools. The process defined in the DSAAPD Quality Management Program ensures immediate identification of quality concerns and implementation of remediation strategies.

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

During in-person monitoring visits, case managers will meet with participants to assess that:

- services are furnished in accordance with the ABI care plan
- participants have access to service identified in the ABI 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 ABI care plan
- patient pay amounts are delineated

Specific methods for carrying out such monitoring are described below.

Case managers will meet in-person with participants and record their observations/findings on a monitoring form. This form will allow the case manager to record a range of information about a participant's receipt of services indicated in the ABI care plan as well as measures of health and well-being. Record will also be made of the receipt of non-waiver services, such as skilled nursing, therapies, and other State Plan services. In addition, case managers will use this form to describe any problems experienced by the participant. During the course of the visit, a participant will be asked if he/she or his/her caregiver knows how to contact the case management provider should questions arise. Importantly, the form will prompt the case manager to indicate whether or not the ABI care plan is meeting the participant's needs or whether an amendment is recommended. Finally, case managers will 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 would trigger a quality assurance and remediation response. (See Appendix H.)

For participants living in assisted living facilities as well as for those living outside of facilities, back-up plans and free-choice of provider issues will be addressed at point of entry, and again during monitoring visits, as needed.

As noted in section D-1, back-up/emergency plans for assisted living residents are provided at the facility level and are required by the state assisted living regulations. The Division of Long Term Care Residents Protection (DLTCRP) is responsible for ensuring that assisted living facilities operate in accordance with these regulations. Facility inspections take place at least annually, or more often if needed.

For participants in assisted living facilities as well as for those who live outside of assisted living,

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plans are also in place for back up services and supplies at the individual level. As described above, case managers will maintain lists of alternate service providers to carry out needed support activities to safeguard the health and welfare of the participant should the regular provider become unavailable.

With regard to freedom of choice, participants will express their choice of provider(s) during the development of the ABI care plan. Case managers will work with participants on an individual basis if, during the course of follow-up monitoring visits, or at any time between visits, the participant expresses the wish to choose a different provider.

c) Planned contacts include at a minimum:

- Monthly in-person contacts by a case manager
- Re-determination visit annually by DSAAPD nurse to be completed between the tenth and twelfth month
- Updated ABI care plan finalized by the end of the twelfth month

b. Monitoring Safeguards. *Select one:*

<input checked="" type="checkbox"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may not provide</i> other direct waiver services to the participant.
<input type="checkbox"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may provide</i> 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. <i>Specify:</i>

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Appendix E: Participant Direction of Services

[NOTE: Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.]

Applicability (select one):

<input type="radio"/>	Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
<input checked="" type="checkbox"/>	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):

<input type="radio"/>	Yes. The State requests that this waiver be considered for Independence Plus designation.
<input type="radio"/>	No. Independence Plus designation is not requested.

Appendix E-1: Overview

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver’s approach to participant direction.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

<input type="radio"/>	Participant – Employer Authority. As specified in <i>Appendix E-2, Item a</i> , the participant (or the participant’s representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
<input type="radio"/>	Participant – Budget Authority. As specified in <i>Appendix E-2, Item b</i> , the participant (or the participant’s representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
<input type="radio"/>	Both Authorities. The waiver provides for both participant direction opportunities as specified in <i>Appendix E-2</i> . Supports and protections are available for participants who exercise these authorities.

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c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

<input type="checkbox"/>	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
<input type="checkbox"/>	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
<input type="checkbox"/>	The participant direction opportunities are available to persons in the following other living arrangements (<i>specify</i>):

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

<input type="radio"/>	Waiver is designed to support only individuals who want to direct their services.
<input type="radio"/>	The waiver is designed to afford every participant (or the participant’s representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input type="radio"/>	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. <i>Specify the criteria:</i>

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant’s representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

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f. Participant Direction by a Representative. Specify the State’s policy concerning the direction of waiver services by a representative (*select one*):

<input type="radio"/>	The State does not provide for the direction of waiver services by a representative.
<input type="radio"/>	The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: (<i>check each that applies</i>):
<input type="checkbox"/>	Waiver services may be directed by a legal representative of the participant.
<input type="checkbox"/>	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

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g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-3. *(Check the opportunity or opportunities available for each service):*

Participant-Directed Waiver Service	Employer Authority	Budget Authority
	<input type="checkbox"/>	<input type="checkbox"/>

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

<input type="radio"/>	Yes. Financial Management Services are furnished through a third party entity. <i>(Complete item E-1-i).</i> Specify whether governmental and/or private entities furnish these services. <i>Check each that applies:</i>
<input type="checkbox"/>	Governmental entities
<input type="checkbox"/>	Private entities
<input type="radio"/>	No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. <i>Do not complete Item E-1-i.</i>

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

<input type="radio"/>	FMS are covered as the waiver service entitled _____ as specified in Appendix C-3.
<input type="radio"/>	FMS are provided as an administrative activity. <i>Provide the following information:</i>
i.	Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services: _____
ii.	Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform: _____
iii.	Scope of FMS. Specify the scope of the supports that FMS entities provide <i>(check each that applies):</i>
	<i>Supports furnished when the participant is the employer of direct support workers:</i>
<input type="checkbox"/>	Assist participant in verifying support worker citizenship status
<input type="checkbox"/>	Collect and process timesheets of support workers
<input type="checkbox"/>	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

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<input type="checkbox"/>	Other (<i>specify</i>):
<i>Supports furnished when the participant exercises budget authority:</i>	
<input type="checkbox"/>	Maintain a separate account for each participant's participant-directed budget
<input type="checkbox"/>	Track and report participant funds, disbursements and the balance-of participant funds
<input type="checkbox"/>	Process and pay invoices for goods and services approved in the service plan
<input type="checkbox"/>	Provide participant with periodic reports of expenditures and the status of the participant-directed budget
<input type="checkbox"/>	Other services and supports (<i>specify</i>):
<i>Additional functions/activities:</i>	
<input type="checkbox"/>	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
<input type="checkbox"/>	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
<input type="checkbox"/>	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
<input type="checkbox"/>	Other (<i>specify</i>):
iv.	Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

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

<input type="checkbox"/>	Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. <i>Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:</i>
<input type="checkbox"/>	Waiver Service Coverage. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled: _____
<input type="checkbox"/>	Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity. <i>Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:</i>

k. Independent Advocacy (*select one*).

<input type="radio"/>	Yes. Independent advocacy is available to participants who direct their services. <i>Describe the nature of this independent advocacy and how participants may access this advocacy:</i>
<input type="radio"/>	No. Arrangements have not been made for independent advocacy.

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

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

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

Table E-1-n		
	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

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Appendix E-2: Opportunities for Participant-Direction

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

i. Participant Employer Status. Specify the participant’s employer status under the waiver. Check each that applies:

<input type="checkbox"/>	Participant/Co-Employer. The participant (or the participant’s representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. <i>Specify the types of agencies (a.k.a., “agencies with choice”) that serve as co-employers of participant-selected staff; the standards and qualifications the State requires of such entities and the safeguards in place to ensure that individuals maintain control and oversight of the employee.:</i>
<input type="checkbox"/>	Participant/Common Law Employer. The participant (or the participant’s representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant’s agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

<input type="checkbox"/>	Recruit staff
<input type="checkbox"/>	Refer staff to agency for hiring (co-employer)
<input type="checkbox"/>	Select staff from worker registry
<input type="checkbox"/>	Hire staff (common law employer)
<input type="checkbox"/>	Verify staff qualifications
<input type="checkbox"/>	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
<input type="checkbox"/>	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
<input type="checkbox"/>	Determine staff duties consistent with the service specifications in Appendix C-3.
<input type="checkbox"/>	Determine staff wages and benefits subject to applicable State limits
<input type="checkbox"/>	Schedule staff
<input type="checkbox"/>	Orient and instruct-staff in duties
<input type="checkbox"/>	Supervise staff
<input type="checkbox"/>	Evaluate staff performance
<input type="checkbox"/>	Verify time worked by staff and approve time sheets
<input type="checkbox"/>	Discharge staff (common law employer)
<input type="checkbox"/>	Discharge staff from providing services (co-employer)
<input type="checkbox"/>	Other (specify):

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b. Participant – Budget Authority (Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b)

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply:*

<input type="checkbox"/>	Reallocate funds among services included in the budget
<input type="checkbox"/>	Determine the amount paid for services within the State’s established limits
<input type="checkbox"/>	Substitute service providers
<input type="checkbox"/>	Schedule the provision of services
<input type="checkbox"/>	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
<input type="checkbox"/>	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
<input type="checkbox"/>	Identify service providers and refer for provider enrollment
<input type="checkbox"/>	Authorize payment for waiver goods and services
<input type="checkbox"/>	Review and approve provider invoices for services rendered
<input type="checkbox"/>	Other (<i>specify</i>):

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

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

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

<input type="radio"/>	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
<input type="radio"/>	Modifications to the participant-directed budget must be preceded by a change in the service plan.

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

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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 Acquired Brain Injury (ABI) Waiver by the assigned DSAAPD nurse. Included in this information is the Fair Hearing notice. The Fair Hearing notice indicates that:

- 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 present a written 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, the actual receipt by the agency of a written request for a Fair Hearing is required within 10 days from the date of notice.
- The individual may write directly to DSAAPD or detach a portion of the notice and mail it to his/her local DSAAPD or DMMA office.

Fair Hearing notices accompany notification of all other adverse actions as well as opportunities for Fair Hearings. In such cases, notices are sent by mail to individual participants by DSAAPD nurse. 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 will be accompanied by the Fair Hearing notice described above. A DSAAPD nurse will assist individuals in pursuing Fair Hearings by referring them to Community Legal Aid services, as needed.

Documentation concerning Fair Hearing notification is kept on file by DSAAPD and DMMA.

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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:*

<input type="radio"/>	Yes. The State operates an additional dispute resolution process (<i>complete Item b</i>)
<input checked="" type="checkbox"/>	No. This Appendix does not apply (<i>do not complete Item b</i>)

- 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.

NA

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Appendix F-3: State Grievance/Complaint System

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

<input checked="" type="checkbox"/>	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 (<i>complete the remaining items</i>).
<input type="checkbox"/>	No. This Appendix does not apply (<i>do not complete the remaining items</i>)

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)
--

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).

<p>(a) Types of grievances/complaints</p> <p>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.</p> <p>(b) Process and timelines for addressing grievances/complaints; and (c) Mechanisms for resolving grievances/complaints</p> <p>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 living in an assisted living facility or outside of an assisted living facility.</p> <p>The table below summarizes the agencies responsible for responding to and resolving grievances/complaints by types of grievances/complaints and location of residence of the waiver participant.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin: 10px 0;"> <thead> <tr> <th style="text-align: center;">Type of grievance/complaint</th> <th style="text-align: center;">Agencies responsible for addressing and resolving grievances/complaints in assisted living (AL)</th> <th style="text-align: center;">Agencies responsible for addressing and resolving grievances/complaints outside of assisted living</th> </tr> </thead> <tbody> <tr> <td>Abuse, neglect or exploitation</td> <td>DLTCRP</td> <td>DSAAPD, Adult Protective Services (APS)</td> </tr> <tr> <td>Non-abuse, neglect or exploitation</td> <td>DSAAPD, Office of State Ombudsman (OSO)</td> <td>DSAAPD, Community Services Program (CSP); DPH (provider issues)</td> </tr> </tbody> </table> <p>Processes and timelines for addressing and resolving grievances/complaints by the responsible agencies are detailed below. Note that responses to and resolution of cases of abuse, neglect or exploitation are addressed fully in Appendix G and will be described here briefly.</p>			Type of grievance/complaint	Agencies responsible for addressing and resolving grievances/complaints in assisted living (AL)	Agencies responsible for addressing and resolving grievances/complaints outside of assisted living	Abuse, neglect or exploitation	DLTCRP	DSAAPD, Adult Protective Services (APS)	Non-abuse, neglect or exploitation	DSAAPD, Office of State Ombudsman (OSO)	DSAAPD, Community Services Program (CSP); DPH (provider issues)
Type of grievance/complaint	Agencies responsible for addressing and resolving grievances/complaints in assisted living (AL)	Agencies responsible for addressing and resolving grievances/complaints outside of assisted living									
Abuse, neglect or exploitation	DLTCRP	DSAAPD, Adult Protective Services (APS)									
Non-abuse, neglect or exploitation	DSAAPD, Office of State Ombudsman (OSO)	DSAAPD, Community Services Program (CSP); DPH (provider issues)									

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Regardless of the nature of the grievance/complaint or the participant's residence, 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 AL

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 12 DE Code § 7971).

Upon admission to a long-term care facility, a resident 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.

The details for responding to critical incidents are found in Appendix G. Appendix H describes the infrastructure that has been developed and implemented to ensure timely notification to DMMA of significant issues. The Quality Management Strategy also describes how DMMA is integrated into the remediation and quality improvement program. See Appendices G & H for details.

Allegations of abuse, neglect or exploitation outside of AL

The Adult Protective Services (APS) program which is administered 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 will be notified of possible APS services during the initial home visit by the CSP staff and nurse. The case management agency will be trained on APS policies and procedures. They will also brief and remind participants, their families, and/or legal representatives about APS services during contacts and re-determination visits. This briefing will include information about APS' after hour client services and contact.

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: Depending on the severity of the grievance/complaint to APS, investigation would commence within hours to the next business day.

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

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findings.

The details for responding to critical incidents are found in Appendix G. Appendix H describes the infrastructure that has been developed and implemented to ensure timely notification to DMMA of significant issues. The Quality Management Strategy also describes how DMMA is integrated into the remediation and quality improvement program. See Appendices G & H for details.

Allegations of other than abuse, neglect or exploitation in AL

The Long-Term Care Ombudsman Program, otherwise known as the Office of State Ombudsman (OSO), which is administered 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 resident 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 are completed according to the timelines outlined in Appendix G.

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.

Appendix H describes the infrastructure that has been developed and implemented to ensure timely notification to DMMA of significant issues. The Quality Management Strategy also describes how DMMA is integrated into the remediation and quality improvement program. See Appendix H for details.

Allegations of other than abuse, neglect or exploitation outside of AL

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,

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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 to 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.

Grievances/complaints about a contracted case management agency can be reported to DSAAPD Community Services Program (CSP) staff. Such grievances/complaints may include but are not limited to grievances/complaints about services, care plans, and/or contracted agency staff. As per DSAAPD’s Service Standard 7:0 (7.7.4 and 7.7.5), a contracted agency must establish written policies regarding quality assurance, participant satisfaction; and grievance/complaint resolution. That standard (7.30) also requires a contracted agency to have an established grievance/complaint resolution process that clearly states how grievances/complaints will be referred to DSAAPD if necessary. The participant will be advised about these rights at the time of enrollment with the contracted agency.

Registering a grievance/complaint will 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 will be 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 will refer 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 will notify the DSAAPD Medicaid Waiver Coordinator for resolution/remediation.

The Waiver Coordinator will work 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 (DMAP’s General Policy, Section 9.0 Appendix D.)

Appendix H describes the infrastructure that has been developed and implemented to ensure timely notification to DMMA of significant issues. The Quality Management Strategy also describes how DMMA is integrated into the remediation and quality improvement program. See Appendix H for details.

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Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. **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).

Background

Delaware law gives authority to the Division of Long Term Care Residents Protection (DLTCRP) to respond to and investigate critical events in licensed long term care facilities, including assisted living. The Division of Services for Aging and Adults with Physical Disabilities' (DSAAPD) Office of the State Ombudsman (OSO) works closely with DLTCRP 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 and disruptive behavior.

Within the ABI Waiver, critical events or incidents will 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;

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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.

- b. 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-a above), the process for providing this information varies somewhat depending on whether or not a waiver participant resides in a licensed assisted living facility. Processes for providing information concerning protections from abuse, neglect, and exploitation for persons living in assisted living facilities and for persons living outside of assisted living facilities are described below.

Information concerning protections from abuse, neglect, and exploitation for waiver participants living in assisted living facilities

At the time of enrollment in assisted living, the assisted living facility admissions director and the case manager will 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. As part of this initial training, 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.

The case manager reinforces this initial training during face-to-face visits. The case manager will be available to assist participants, families, and/or legal representatives with filing a report, if necessary.

In addition, upon admission to an assisted living facility, 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

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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 assisted living facility.

Information concerning protections from abuse, neglect, and exploitation for waiver participants living outside of assisted living 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 will be 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. The case manager will also be trained on APS policies and procedures, and will 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.

- c. **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 in assisted living facilities

As stated in G-1-a, incidents for which DLTCRP has oversight responsibility must be reported by the assisted living 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 will investigate incidents with participants. Once a complaint or report is received, OSO and/or DLTCRP will 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 will determine 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

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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 will initiate an investigation within the established timeline based on the type of incident. OSO will refer any complaint involving abuse, neglect, mistreatment, or exploitation to DLTCRP within 8 hours (next business day). For a complaint of actual or threatened transfer or discharge from a facility, OSO will initiate an investigation by the end of the 5th business day, or the last day of bed hold, or prior to the last day for filing an appeal for an administrative hearing (depending on which occurs first). For all other types of complaints, OSO will initiate an investigation within 10 business days. Generally, reports received by OSO are entered 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 will be investigated within 48 hours; an incident of actual harm will be investigated within 3 working days and completed within 10 days; an incident with a potential for more than minimal harm, will be investigated within 10 working days and completed within 30 days; an incident with a potential for minimal harm will be investigated within 10 working days, and completed within 45 days; all investigations not addressed above shall be 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 outside of assisted living facilities

APS is the designated agency to receive, investigate, and respond to critical incidents of abuse or neglect of clients living outside of assisted living facilities.

Incidents of sexual abuse, physical abuse or severe neglect 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 will make an unannounced visit to assess the participant and his/her situation. The social worker will gather 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 themselves, 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 met, and therefore formulating an appropriate service plan to meet these needs.

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Where the APS social worker substantiates the complaint and determines that the adult is in need of protective services, the APS worker will establish 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 will be shared with DSAAPD and the contracted case management agency. The goals and objectives of the APS care plan will then be integrated with the current ABI care plan. Where 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 will be 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.

- d. 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 assisted living facilities

DLTCRP has responsibility for oversight and follow-up of incidents involving ABI waiver participants in assisted living facilities. Assisted living facilities are required to report incidents within 8 hours of notification of, or knowledge of, an incident as listed in G-1-a. DLTCRP will research all critical incidents listed in G-1-a through participant interviews, ABI waiver provider interviews, review of pertinent records and case conferences with all necessary parties. DLTCRP may request that further follow-up be provided by ABI provider and/or in some cases, by other appropriate investigatory agencies (ex; Professional Regulations, DPH, DSAAPD, OSO, and the Attorney General’s office).

On a monthly basis, DLTCRP will provide OSO with data reports regarding incidents for their review. DLTCRP and OSO meet on a quarterly basis to review information that has been previously provided and discuss any findings related to incident reporting or other related issues or concerns. This meeting may occur more frequently if needed. DLTCRP and OSO may request additional information of assisted living facilities. At a minimum, DLTCRP surveys will be conducted on an annual basis, or on an as needed basis, in response to a specific event or incident.

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. Assisted living facilities and the OSO will 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. On a monthly basis, OSO will analyze all incident occurrence data collected from all sources including DLTCRP, DSAAPD, and OSO Production System for identification of trend and pattern. The analysis will be shared with DSAAPD’s Quality Improvement Committee (QIC) on a monthly basis and reported to the DMMA Quality Initiative Improvement (QII) Task Force on a quarterly basis. In accordance

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with the Quality Management Strategy, the QII Task Force will report this information to the DMMA Leadership Team. On a semi-annual basis, DSAAPD's QIC and the OSO will meet with assisted living providers to discuss survey and data findings.

Responsibility for oversight of critical incidents and events outside of assisted living facilities

APS has responsibility for oversight and follow-up of incidents involving ABI waiver participants outside of assisted living facilities.

APS keeps detailed statistics on cases by category and resolution along with time frames. Referrals and investigations regarding all cases will be documented and communicated to DSAAPD administration and the contracted case management agency. This information will be reviewed by the APS advisory board composed of 15 members from across the community. APS will analyze and report on waiver participant critical incidents to the DSAAPD Waiver Coordinator and the DHSS Constituent Relations Director on a monthly basis. The Waiver Coordinator will present the findings from APS analysis to DSAAPD's Quality Improvement Committee (QIC) on a monthly basis. In turn, this information and DSAAPD's recommendations will be reported to DMMA's Quality Initiative Improvement (QII) Task Force on a quarterly basis. In accordance with the Quality Management Strategy, the QII Task Force will report this information to the DMMA Leadership Team.

On a semi-annual basis, DSAAPD's QIC, OSO, and APS will meet with ABI providers to discuss data findings.

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Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

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

<input checked="" type="checkbox"/>	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:																
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Agency</th> <th style="width: 25%;">Provider Type</th> <th style="width: 25%;">Strategy</th> <th style="width: 25%;">Frequency</th> </tr> </thead> <tbody> <tr> <td>DLTCRP</td> <td>Assisted Living (AL)</td> <td> <ul style="list-style-type: none"> • Licensure Survey • Complaint Surveys </td> <td> <ul style="list-style-type: none"> • Annual • As needed </td> </tr> <tr> <td> DSAAPD <ul style="list-style-type: none"> • OSO • Nurses • Case Management </td> <td> <ul style="list-style-type: none"> • AL • AL • All community-based providers and AL </td> <td> <ul style="list-style-type: none"> • Complaint remediation/resolution • Monitoring site visits • Care plan monitoring </td> <td> <ul style="list-style-type: none"> • As needed • Quarterly • Ongoing </td> </tr> <tr> <td>DPH</td> <td> <ul style="list-style-type: none"> • Home Health Agencies • Adult Day Care </td> <td> <ul style="list-style-type: none"> • Licensure site survey • Complaint remediation and resolution </td> <td> <ul style="list-style-type: none"> • Initial application • Renewals as needed </td> </tr> </tbody> </table>	Agency	Provider Type	Strategy	Frequency	DLTCRP	Assisted Living (AL)	<ul style="list-style-type: none"> • Licensure Survey • Complaint Surveys 	<ul style="list-style-type: none"> • Annual • As needed 	DSAAPD <ul style="list-style-type: none"> • OSO • Nurses • Case Management 	<ul style="list-style-type: none"> • AL • AL • All community-based providers and AL 	<ul style="list-style-type: none"> • Complaint remediation/resolution • Monitoring site visits • Care plan monitoring 	<ul style="list-style-type: none"> • As needed • Quarterly • Ongoing 	DPH	<ul style="list-style-type: none"> • Home Health Agencies • Adult Day Care 	<ul style="list-style-type: none"> • Licensure site survey • Complaint remediation and resolution 	<ul style="list-style-type: none"> • Initial application • Renewals as needed
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DPH	<ul style="list-style-type: none"> • Home Health Agencies • Adult Day Care 	<ul style="list-style-type: none"> • Licensure site survey • Complaint remediation and resolution 	<ul style="list-style-type: none"> • Initial application • Renewals as needed 														
<input type="checkbox"/>	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).

N/A

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:

N/A

b. Use of Restrictive Interventions

<input checked="" type="checkbox"/>	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:								
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Agency</th> <th style="width: 25%;">Provider Type</th> <th style="width: 25%;">Strategy</th> <th style="width: 25%;">Frequency</th> </tr> </thead> <tbody> <tr> <td>DLTCRP</td> <td>Assisted Living</td> <td> <ul style="list-style-type: none"> • Licensure Survey </td> <td> <ul style="list-style-type: none"> • Annual </td> </tr> </tbody> </table>	Agency	Provider Type	Strategy	Frequency	DLTCRP	Assisted Living	<ul style="list-style-type: none"> • Licensure Survey 	<ul style="list-style-type: none"> • Annual
Agency	Provider Type	Strategy	Frequency						
DLTCRP	Assisted Living	<ul style="list-style-type: none"> • Licensure Survey 	<ul style="list-style-type: none"> • Annual 						

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		(AL)	<ul style="list-style-type: none"> Complaint Surveys 	<ul style="list-style-type: none"> As needed
	DSAAPD <ul style="list-style-type: none"> OSO Nurses Case Management 	<ul style="list-style-type: none"> AL AL All community-based providers and AL 	<ul style="list-style-type: none"> Complaint remediation/resolution Monitoring site visits Care plan monitoring 	<ul style="list-style-type: none"> As needed Quarterly Ongoing
	DPH	<ul style="list-style-type: none"> Home Health Agencies Adult Day Care 	<ul style="list-style-type: none"> Licensure site survey Complaint remediation and resolution 	<ul style="list-style-type: none"> 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-a-ii:			

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- 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.

N/A

- 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:

N/A

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Appendix G-3: Medication Management and Administration

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:

<input checked="" type="checkbox"/>	Yes. This Appendix applies (<i>complete the remaining items</i>). For ABI Waiver participants in assisted living facilities.
<input type="checkbox"/>	No. This Appendix is not applicable (<i>do not complete the remaining items</i>).

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 assisted living facility’s nursing staff have “first line” responsibility for assuring that ABI 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 quarterly review of the medication regimen 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 initially, 30 days after admission, and at a minimum, annually conducts a reassessment of the participant’s status.

At each AL service agreement meeting with a participant, the assisted living facility nurse is responsible for:

- confirming that the level of medication assistance ordered in the participant’s service agreement 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

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to the Delaware Office of Narcotics and Dangerous Drugs.

DLTCRP is responsible for conducting annual surveys of the assisted living 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 assisted living facility survey; and
- investigating 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 ABI assisted living facilities to review medication regimens for any potentially harmful medications (e.g., behavior modifiers such as antidepressants.) As stated previously in Appendix G-1-a, OSO and DLTCRP are informed of any significant medication errors and follow-up.

DLTCRP monitors medication management practices through regular survey activities and complaints. 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 assisted living facility will advise DLTCRP about any concerns or adverse experiences regarding medication errors. DLTCRP will provide a report to OSO regarding the outcome of any complaints referred by OSO to DLTCRP for investigation, and will provide the outcomes of survey activity and any plans of corrections.

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

In addition, DSAAPD nurses will conduct face-to-face visits with ABI participants residing in AL at least four times in the first year of residency, and at least three times in subsequent years. During such visits, ABI participant records will be reviewed for compliance. The outcome of such a review, any out of compliance information and subsequent plan of

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correction will be shared with DLTCRP and the OSO. DSAAPD nurses and the OSO will share information with the ABI provider, and continue to monitor compliance during facility visits.

On a monthly basis, OSO will analyze all incident occurrences and statistics collected from all sources for identification of trends and patterns. The analysis will be shared with DSAAPD’s Quality Improvement Committee (QIC) on a monthly basis and reported to DMMA’s Quality Initiative Improvement (QII) Task Force on a quarterly basis. In accordance with the Quality Management Strategy, the QII Task Force will report this information to the DMMA Leadership Team.

On a semi-annual basis, DSAAPD’s QIC, OSO, and APS will meet with ABI providers to discuss data findings.

c. Medication Administration by Waiver Providers

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

<input checked="" type="checkbox"/>	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. <i>(complete the remaining items)</i>
<input type="checkbox"/>	Not applicable <i>(do not complete the remaining items)</i>

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 that assisted living facilities maintain records of those persons who have fulfilled the above-referenced requirements for assisting residents with the self-administration of medications.

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

<input checked="" type="checkbox"/>	Providers that are responsible for medication administration are required to <i>both</i> record and report medication errors to a State agency (or agencies). <i>Complete the following three items:</i>
	(a) Specify State agency (or agencies) to which errors are reported: DLTCRP
	(b) Specify the types of medication errors that providers are required to <i>record</i> : All medication errors
	(c) Specify the types of medication errors that providers must <i>report</i> to the State: Significant error or omission 19.7.7.5 of the Regulations
<input type="checkbox"/>	Providers responsible for medication administration are required to <i>record</i> 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: N/A

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 the assisted living facility 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 will provide a report regarding the outcome of survey activity and plans of corrections to OSO.

Standardized communications regarding medication errors and/or omissions and other deficiencies that adversely impact ABI participants have been established through a formal operating agreement between OSO and DLTCRP.

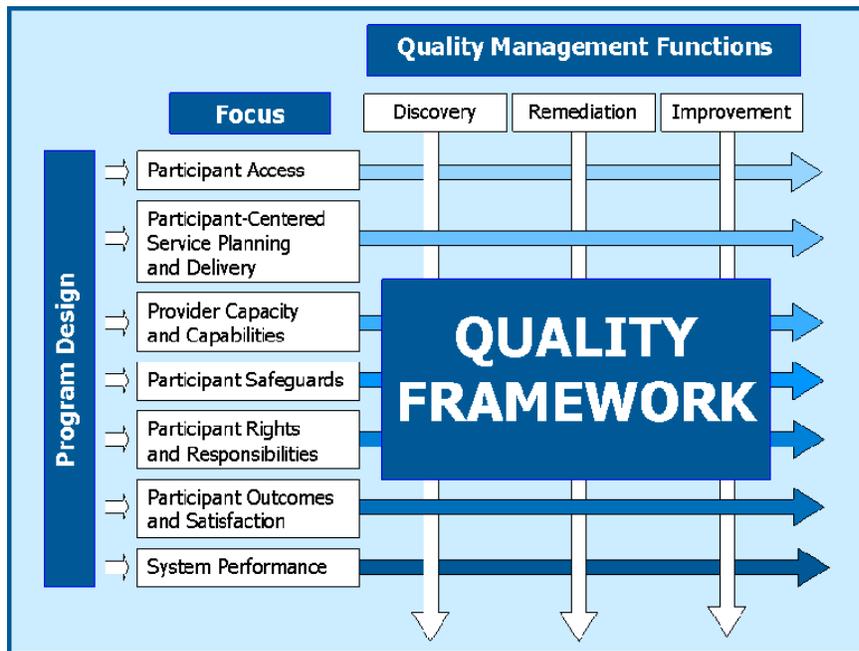
On a monthly basis, OSO will analyze all incident occurrences and statistics collected from all sources for identification of trends and patterns. The analysis will be shared with DSAAPD’s Quality Improvement Committee (QIC) on a monthly basis, and reported to DMMA’s Quality Initiative Improvement (QII) Task Force on a quarterly basis. In accordance with the Quality Management Strategy, the QII Task Force will report this information to the DMMA Leadership Team.

On a semi-annual basis, DSAAPD’s QIC, OSO, and APS will meet with ABI providers to discuss data findings.

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Appendix H: Quality Management Strategy

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 Management 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 Management 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 Management 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 Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

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Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS, a state spells out:

- The evidence based *discovery* activities that will be conducted for each of the six major waiver assurances;
- The *remediation* processes followed when problems are identified in the implementation of each of the assurances;
- The *system improvement* processes followed in response to aggregated, analyzed information collected on each of the assurances;
- The correspondent *roles/responsibilities* of those conducting discovery activities, assessing, remediating and improving system functions around the assurances; and

The process that the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

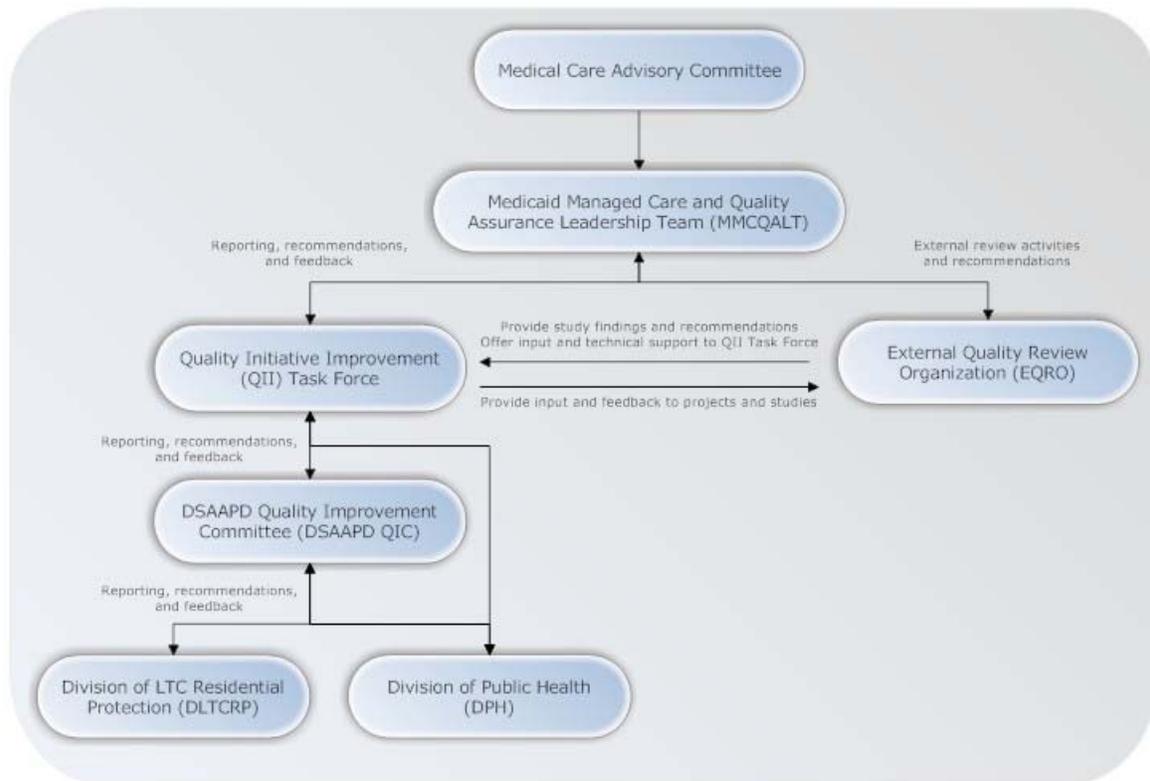
If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in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

When the Quality Management 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 identify the other long-term services that are addressed in the Quality Management Strategy.

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The Quality Management Strategy for the waiver is:

Delaware’s Integrated Quality Management Strategy



Introduction

Delaware Health and Social Services (DHSS), Division of Medicaid & Medical Assistance (DMMA) developed and implemented its Quality Management Strategy (QMS) to promote an integrated, collaborative quality management approach among DMMA, managed care, waiver, and other medical assistance programs. Delaware’s QMS mission is to:

- Assure Medicaid enrollees receive quality care and services identified in Waivers and Medicaid funded programs by providing oversight for monitoring and tracking activities of quality plans, assurances and improvement activities;
- Provide ongoing oversight responsibilities assuring Medicaid funded program quality plans meet CMS requirements of “achieving ongoing compliance with the waiver assurances” and other federal requirements.

Delaware’s QMS model provides ongoing assurance that the quality of care offered under the Acquired Brain Injury (ABI) Waiver program is integrated across three levels of accountability. DMMA is the Medicaid agency that has oversight responsibility for Medicaid and waiver programs. DMMA delegated the operation of the Acquired Brain Injury waiver program to the Division of Services for the Aging and Adults with Physical Disabilities (DSAAPD) whose roles and responsibilities are defined in a Memorandum of Understanding (MOU 7/07) developed collaboratively between the two agencies. Where the client is receiving assisted living services under the ABI waiver, DSAAPD delegates assisted living facilities licensure to the Division of Long Term Care Residents Protection (DLTCRP) through a MOU. DLTCRP is integrated into

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the QMS through the DSAAPD Quality Improvement Committee (QIC) and is responsible for the collection and reporting of consumer and stakeholder concerns and complaints for waiver participants living in assisted living facilities. The Delaware Division of Public Health (DPH) has responsibility for the licensure of community-based providers such as home health agencies and adult day care centers. DPH is already directly integrated into the QMS as an active participant in Medicaid’s Quality Initiative Improvement (QII) Task Force (described later in this section of the waiver application). In addition, DPH’s provider contracting monitoring and reporting efforts will be integrated into DSAAPD’s quality management reporting and monitoring (coordinated by DSAAPD’s Waiver Coordinator and Quality Improvement Committee) for ABI community-based waiver providers who are licensed by the division.

Using the HCBS quality framework as its foundation (e.g., design, discovery, remediation, and improvement), Delaware’s QMS plan encompasses an integrated, coordinated and continuous quality improvement system that promotes compliance with waiver requirements, CMS waiver assurances, and its component elements. Delaware’s QMS defines the roles and responsibilities of multi-disciplinary committees, task forces, and work groups that are ultimately responsible for the development, implementation, monitoring, and evaluation of the ABI program and its quality initiatives. During the first year of the ABI Waiver, Delaware’s QMS will focus on (1) the collaborative identification, design and implementation of quality indicators, (2) the application of discovery processes resulting in baseline measurements for all indicators, and (3) assessment of provider and operational compliance with waiver requirements. The second year’s ABI QMS activities will include: (1) collection of baseline measurement results for all indicators, (2) analysis of results and comparison to national standards, where applicable, (3) establishment of priorities, goals, and objectives based on baseline measurement results, and (4) development of quality improvement interventions and strategies for remediation to improve quality and performance. Subsequent years will focus on the cycle of re-measurement, evaluation of effectiveness, and remediation to improve performance.

Subsequent discussion will demonstrate how Delaware’s QMS addresses the processes of discovery, remediation and improvement; the frequency of such processes; the sources of information used to measure performance; and key roles and responsibilities for managing quality, and the mechanisms used to report information to internal and external stakeholders involved in the program. The following provides a detailed description of how the Delaware QMS meets each of the five requirements identified in the waiver application.

Requirement H1: Waiver Assurances

Requirement H1 Response: Please see *Attachment to H1: Delaware’s ABI Waiver Assurance Monitoring & Reporting Strategy* for a detailed description of the reporting and monitoring strategy for each assurance requirement including the: discovery process(es); entities or individuals responsible for conducting the discovery/monitoring processes; the types of information used to measure performance; and the frequency with which performance is measured. The following is a listing of the HCBS waiver programs (and their control numbers) that have been integrated into the Delaware Medicaid QMS: Developmentally Disabled Waiver (0009.00.R4); Assisted Living Waiver (0352.91R1); Elderly and Disabled Waiver (0136.90.R3); and HIV/AIDS Waiver (4159390.R2).

Requirement H2: Roles and Responsibilities

Requirement H2 Response: Delaware’s QMS was developed to promote integration and collaboration both vertically and horizontally across state agencies and externally with key

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stakeholder groups including CMS, advocacy groups, providers, and waiver participants. The following table details the roles and responsibilities of multi-disciplinary committees, task forces, and work groups that are responsible for the development, implementation, monitoring, and evaluation of the ABI program and its quality initiatives.

Table 1: Delaware QMS Integrated/Collaborative Model: Roles and Responsibilities

Entity	Membership	Roles and Responsibilities
Medical Care Advisory Committee (MCAC)	<ul style="list-style-type: none"> • CMS • Providers • Advocacy • Enrollees/Clients • Medicaid Leadership 	<ul style="list-style-type: none"> • Review of QMS efforts. • Forum for input from key stakeholders in to quality efforts and key clinical management concerns. • Forum for input on State policy for health care delivery to Medicaid enrollees.
Medicaid Managed Care and Quality Assurance Leadership Team (MMCQALT)	<ul style="list-style-type: none"> • Medicaid Leadership • Medical Director • EQRO Consultant 	<ul style="list-style-type: none"> • Oversight of QMS. • Development of reporting to Medical Advisory Committee. • Communication and support of Stakeholder Advisory groups. • Oversight and direction to the Quality Improvement Initiative Task Force.
Quality Initiative Improvement (QII) Task Force	<ul style="list-style-type: none"> • Medicaid Quality Assurance Leadership • Representatives from all Medicaid funded programs • Representatives from Agencies' Quality Committees responsible for waiver programs 	<ul style="list-style-type: none"> • Development and implementation of Medicaid QMS. • Integration of Medicaid QMS with managed care and waiver quality strategies. • Oversight and technical support. • Provides forum for best practice sharing. • Provides support and feedback to waiver programs for the: • Establishment of priorities. • Identification, design, and implementation of quality reporting and monitoring. • Review of findings from discovery processes. • Development of remediation strategies and corrective action plans if appropriate. • Identification and implementation of quality improvement strategies. • Provides feedback on quality measurement and improvement strategies to participating agencies and program staff. • Reporting to Medicaid Managed Care Quality Assurance Leadership Team.

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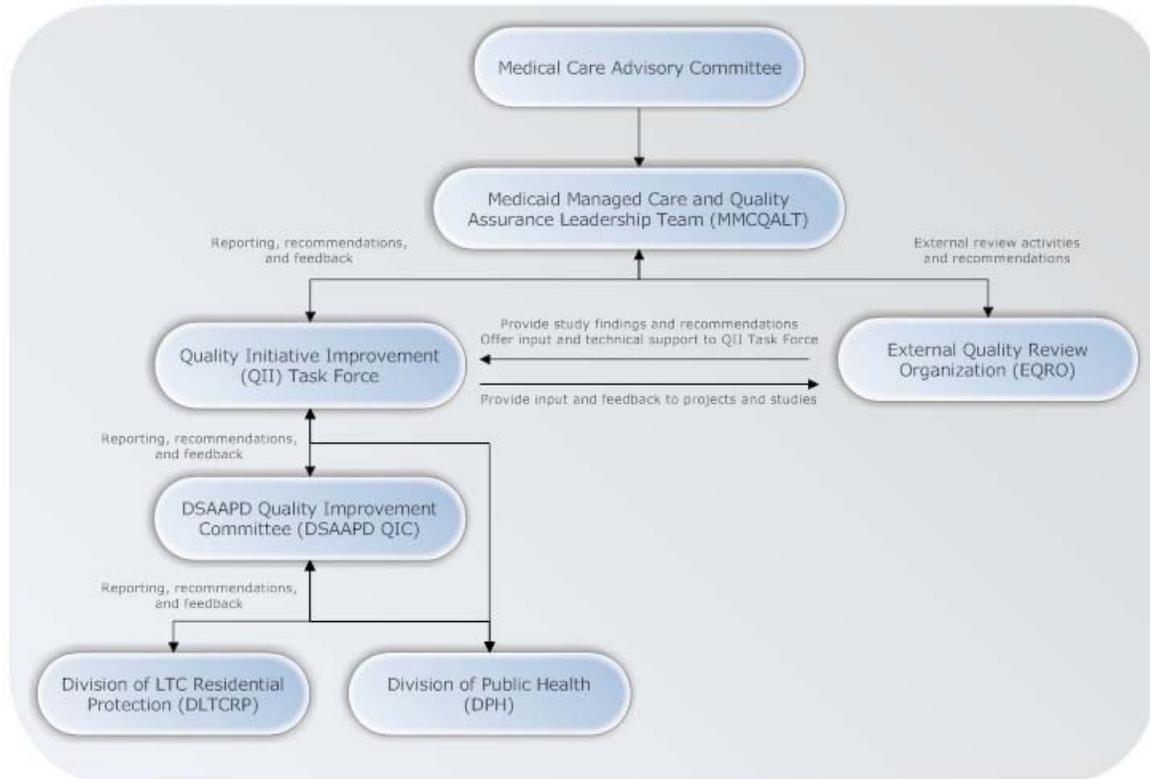
Entity	Membership	Roles and Responsibilities
DSAAPD Quality Improvement Committee (QIC)	<ul style="list-style-type: none"> • DSAAPD Operations Manager • DSAAPD Waiver Coordinator • DSAAPD Nurses • DSAAPD Community Services Program (CSP) Staff • DSAAPD Ombudsman • DLTCRP Representatives • DSAAPD Planning and Analysis Staff • DSAAPD APS Representatives • DPH Representatives 	<ul style="list-style-type: none"> • Oversight. • Priority setting. • Monitoring and reporting. • Establishment of priorities. • Identification, design, and implementation of quality reporting and monitoring. • Review of findings from discovery processes. • Development of remediation strategies which may include corrective action plans. • Identification and implementation of quality improvement strategies.
DSAAPD Waiver Coordinator	<ul style="list-style-type: none"> • Waiver Coordinator 	<ul style="list-style-type: none"> • Facilitates and supports QIC • Coordinates and organizes all QIC monitoring and reporting activities • Summarizes monitoring and reporting results and presents to QIC • Documents all QIC meeting minutes • Supports presentation of QIC reports to QII Task Force • Develops QIC quarterly reports with DSAAPD, DLTCRP, and DPH representatives
Division of Long Term Care Residents Protection (DLTCRP)	<ul style="list-style-type: none"> • LTC licensing and monitoring staff (for the Assisted Living component). 	<ul style="list-style-type: none"> • Provider monitoring and reporting. • Participation in the DSAPD QIC • Participation in the DMMA QII Task Force.
Division of Public Health (DPH)	<ul style="list-style-type: none"> • Licensing for Community-Based Waiver Providers (e.g., Home Health, Adult Day Care) 	<ul style="list-style-type: none"> • Provider monitoring and reporting. • Participation in the DSAPD QIC • Participation in the DMMA QII Task Force.
Acquired Brain Injury Waiver Providers	<ul style="list-style-type: none"> • Case Managers • ABI Service Providers 	<ul style="list-style-type: none"> • Participation in ABI Quality Improvement initiatives. • Data reporting.

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The following illustration depicts the oversight, accountability, and integration of information across Delaware’s QMS for its waiver programs. This structure promotes a highly effective collaborative approach for ongoing discovery, establishment of priorities, and development of strategies for remediation and improvement.

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Illustration 1: Delaware QMS Reporting Relationships and Information Flow

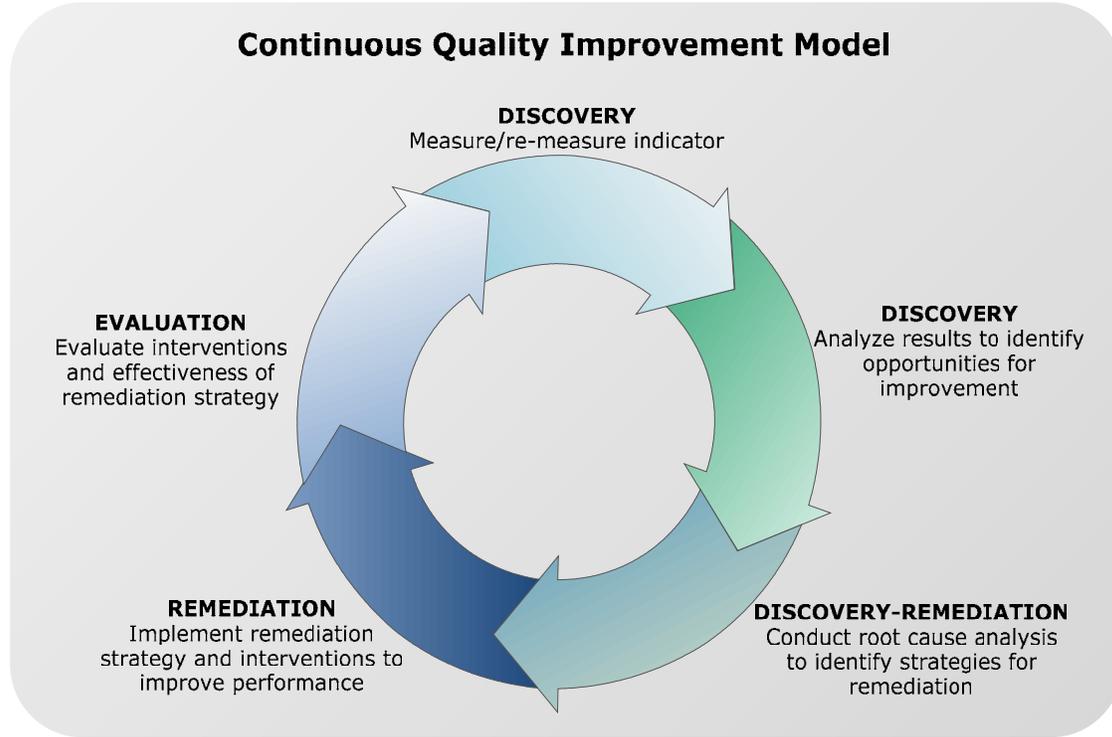


Requirement H3: Processes to Establish Priorities and Develop Strategies for Remediation and Improvement

Requirement H3 Response: The Delaware QMS encompasses a continuous quality improvement (CQI) process and problem-solving approach that is applied to specific and measurable performance indicators and operational activities. The CQI process is used to: (1) monitor quality of care, service indicator, and operational performance, (2) identify opportunities for improvement that exist throughout the program, (3) implement remediation strategies to improve outcomes and performance, and (4) evaluate interventions to ensure remediation strategy was successful. The process employed to review findings from discovery activities, establish priorities, and develop strategies for remediation and improvement is depicted in Illustration 2 below.

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Illustration 2: Continuous Quality Improvement (CQI) Model



As part of its discovery process, the DSAAPD QIC established the following list of criteria for identifying and prioritizing study topics, which includes, but is not limited to:

- The topic reflects the distribution of healthcare concerns for participants.
- The topic is a high risk, high volume, high cost, or problem prone topic.
- Regulatory or accrediting bodies require study or examination of this topic.
- There are objective criteria for assessing care in the selected area.
- There is likelihood that participant health status may be improved.
- The topic reflects and supports the attainment of departmental or division goals.

Once the ABI indicators and study topics are established, the DSAAPD QIC determines the design and methodology used to collect data that will objectively measure performance.

Upon determining the methodology for data collection and analysis, a baseline measurement is conducted to establish the value to which other measurement results are compared. Once data is collected, analysis occurs to identify opportunities for improvement (OFI). These steps occur during the discovery stage. Further analysis reveals the root cause of the problem or barrier that impacts performance and/or quality improvement. Once the root cause is determined, the remediation strategy is developed to correct identified problems at the individual, provider, or system level. After employing the remediation strategy, another evaluation occurs to assess the effectiveness of the remediation strategy. This occurs through indicator remeasurement and evaluation. If demonstrable improvement from baseline to remeasurement is not made, the cycle repeats itself for that specific indicator. If, after several remeasurement periods it is determined

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that significant improvement was achieved, the indicator/study topic retires, or is monitored less frequently. However, if performance for a specific topic declines, the CQI process begins and the cycle repeats. In addition to these activities, research, resolution, and remediation occurs within the grievance/complaint process(es) that have been enhanced within DSAAPD, DLTCRP, and DPH to serve the ABI Waiver participants and providers. The following table summarizes the accountabilities, quality management reporting strategy; and remediation activities:

Table 3: Grievance/Complaints Processes: Remediation Strategies

Accountability	Area of Focus	Quality Reporting & Monitoring	Remediation	
			Individual	System-wide
DSAAPD – OSO	AL Residents	OSO → Waiver Coordinator → QIC	<ul style="list-style-type: none"> • Works directly with waiver participant and providers • Reports results back to CSP Supervisor & QIC 	Provides summarized data to QIC for feedback and remediation recommendations for system-wide improvements
DSAAPD – APS	Non-AL Waiver Participants (Neglect, Abuse, etc.)	APS → OSO → Waiver Coordinator → QIC	<ul style="list-style-type: none"> • Works directly with waiver participant and other necessary providers/agencies • Agency, Waiver Participant, Case Referral Source, Case Manager 	Provides summarized data to QIC for feedback and remediation recommendations for system-wide improvements
DSAAPD – Community Services Program (CSP)	<ul style="list-style-type: none"> • Waiver Participants • Providers 	CSP → Waiver Coordinator → QIC	<ul style="list-style-type: none"> • Works directly with waiver participant and providers • Coordinates with Waiver Coordinator for difficult cases to obtain Medicaid technical support for administering DMMS policy and procedure • Reports results back to CSP Supervisor & QIC 	Provides summarized data to QIC for feedback and remediation recommendations for system-wide improvements
DLTCRP	AL Facilities – Providers	DLTCRP → OSO → Waiver Coordinator → QIC	<ul style="list-style-type: none"> • Works directly with AL facilities • Reports results back to CSP Supervisor & QIC 	Provides summarized data to QIC for feedback and remediation recommendations for system-wide improvements

Table 1 details the roles and responsibilities of multi-disciplinary committees, task forces, and work groups that are responsible for the development, implementation, monitoring, and evaluation of the ABI program and its quality initiatives. The DSAAPD QIC has responsibility

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for reviewing the findings from discovery activities, establishing priorities, and developing strategies for remediation and improvement. The QII Task Force provides a forum for collaboration and development of systematic and integrated approaches to quality activities. In a non-threatening environment, the QIC (1) obtains feedback on the findings from the other waiver and managed care programs, (2) obtains technical support for establishing priorities, and (3) compares finding to national standards that assist in driving remediation and improvement activities.

Illustration 1 depicts the oversight, accountability, and integration of information across Delaware’s QMS for its waiver programs. This structure promotes a highly effective collaborative approach for ongoing discovery, establishment of priorities, and development of strategies for remediation and improvement.

Requirement H4: Compilation and Communication of Quality Management Information

Requirement H4 Response: Delaware’s QMS has several integrated processes for compiling and communicating quality management information to internal (state agencies, state leadership) and external stakeholder (waiver participants, families, waiver service providers, other interested parties) groups. The following is a summary of these key processes and Table 3 which provides a detailed listing of the type of quality management reports that support DE’s QMS:

- DSAAPD staff collects and analyzes quality monitoring and reporting data. These data analyses and findings are presented to the QIC on a quarterly basis. The QIC reviews these data elements to identify trends and opportunities for improvement at both the provider and program operations level. This information is reported to the DMMA QII Task Force on a quarterly basis through a reporting schedule established by the QII. Presentations may be made quarterly by DSAAPD QII Task Force members to the QII Task Force utilizing this forum for feedback, sharing results and best practices.
- DSAAPD and other agencies responsible for the waiver programs meet with provider groups on a semiannual or more frequent basis as needed. These meetings allow for sharing results from the quality management activities, incorporating feedback from the providers into quality improvement strategies, and education and training. In addition, DSAAPD nurses meet with individual Acquired Brain Injury AL Facility providers on a quarterly basis to conduct quality monitoring activities and share individual results from these efforts. These visits may be conducted more frequently when opportunities for improvement are identified from the assurance monitoring activities described under the response to requirement 1 above. The types of quality management reports that are compiled and shared with internal and external stakeholders are detailed below.

Table 3: Types of Quality Management Reports

Type of Report	Frequency of Report	Stakeholder Communication Strategy
Monthly Oversight Report – a compilation of data and information from Waiver quality initiatives.	Monthly	The QII Task Force submits a monthly oversight and activity report to the DMMA MMCQALT. The MMCQALT reviews and distributes report to internal stakeholder groups for informational purposes and to obtain feedback and recommendations to improve waiver operations.

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Type of Report	Frequency of Report	Stakeholder Communication Strategy
Quality Indicator Report – the actual results of quality indicators compared to the goals identified for each indicator. Although results may be captured more frequently, the compilation of data occurs annually.	Quarterly	The report is presented to internal stakeholders and is part of the DSAAPD Quality Report to the QII Task Force.
Level of Care (LOC) Evaluation Report – provides information on the percentage of cases that adequately met level of care criteria for the program.	Quarterly	DSAAPD staff present findings to the QII Task Force on a quarterly basis.
Service Utilization Report – the actual services utilized per Waiver participant.	Monthly	The Service Utilization Report is submitted to the DSAAPD Waiver Coordinator on a monthly basis for the purpose of comparing actual service utilization per individual to the individual service plans (aka ABI Care Plans) in an effort to detect over/under-utilization of services and adjust/modify the waiver participants’ ABI Care Plans based on the comparison.
Prior Authorization Report – DMMA SUR unit monitors service utilization against services authorized.	Quarterly	Results of the analysis are shared with DSAAPD staff on a quarterly basis.
Participant Satisfaction Report <ul style="list-style-type: none"> • Ombudsman team conducts waiver participant surveys for AL residents. • DMMA’s long term care and waiver financial unit conducts client satisfaction surveys of LTC and waiver participants, or their representatives after contact with financial unit representatives. 	Annually	The QIC will utilize the reports from these survey activities to identify ABI Waive Specific issues.
Provider Satisfaction Report - DMMA’s Provider Relations Agent conducts provider satisfaction surveys	Annually	The DSAAPD QIC will utilize this vehicle to identify ABI Waiver specific issues.
DSAAPD Quality Report - details the quality activities, utilization trends, participant and provider satisfaction, and other activities that are part of the Waiver program.	Quarterly	The report is presented to the DMMA QII Task Force on a quarterly basis. An annual roll-up of the previous year’s activities is also provided to the DMMA QII Task Force.
EQRO Report – a summary of the monitoring and improvement activities and indicator results for the Medicaid and Wavier programs.	Annually	Report is distributed to internal and external stakeholders and the general public annually through website posting.
QMS Evaluation - DMMA conducts a formal annual evaluation of the QMS to assess the overall effectiveness of the QMS.	At least annually	Annual evaluation of the QMS incorporates feedback from all internal and external stakeholders. The revised QMS is available to all internal and external stakeholders at least annually, or as often as changes to the QMS occur.

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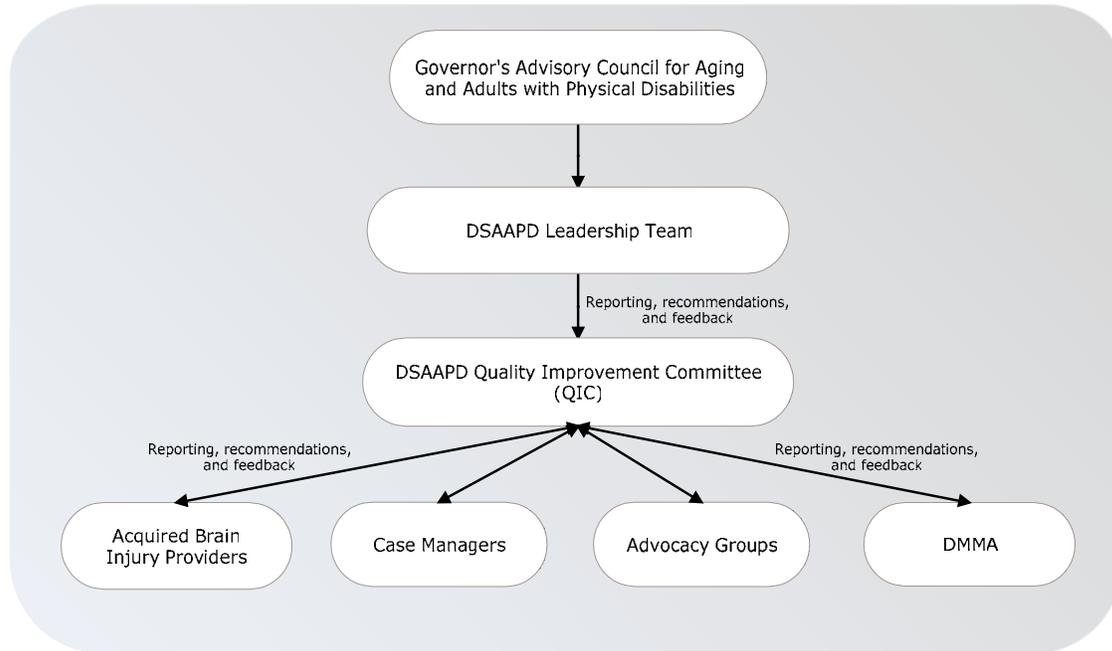
Type of Report	Frequency of Report	Stakeholder Communication Strategy
Annual CMS Waiver Report – the annual compilation of data and waiver activities as presented in various quarterly and annual reports and the annual EQRO report.	Annually	Annual report submitted to CMS, and is available to internal and external stakeholders.
Quality Courier Newsletter – newsletter containing the results of quality monitoring and improvement activities produced by the EQRO.	Semiannually	Newsletter is published by the EQRO and presented to Medicaid providers via hard-copy and web on a semiannual basis.

Illustration 3 below describes the infrastructure developed within DSAAPD to support ongoing communication and feedback regarding the agencies’ quality management strategy and activities from waiver participants, families, waiver service providers, other interested parties, and the public. The following activities support this communication linkage:

- The Governor’s Advisory Council for Aging and Adults with Physical Disabilities provides oversight to DSAAPD on an ongoing basis through quarterly meetings between its participants (advocacy group representatives, consumers, providers, and other key stakeholders) and the DSAAPD leadership team. DSAAPD’s leadership will provide QIC updates to this group on a quarterly basis to ensure that they have ongoing knowledge of all quality management activities and have an opportunity to provide input and feedback.
- DSAAPD staff will meet with the Acquired Brain Injury providers, with particular emphasis on the Case Managers, on a quarterly basis to provide updates on quality initiatives and obtain input and feedback on current and future initiatives. In addition, this forum will provide an opportunity to provide feedback to providers on DSAAPD’s provider related quality measurement and improvement activities. This group will also serve as the source for obtaining provider support and participation for the QIC’s quality studies and improvement initiatives.
- DMMA’s provider relations agent coordinates provider meetings for all Medicaid and waiver providers in Delaware on a quarterly basis. The QIC will utilize this forum for soliciting feedback and input on its quality management efforts on an ongoing basis.

Illustration 3: DSAAPD Quality Monitoring and Reporting Relationships

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Requirement H5: Periodic Evaluation and Revision of the QMS

Requirement H5: Response: Delaware’s QMS is a continuous, evolving, and dynamic infrastructure designed to monitor and improve the delivery of health care services to the targeted populations in its Waiver programs. Evaluations occur through regularly scheduled reporting activities whereby the DSAAPD QIC, QII Task Force, and/or the MMCQALT may make recommendations and changes to the program based on adverse trends in data or program operations.

DMMA leadership works closely with the EQRO throughout the year to support, oversee, monitor, and evaluate the quality management activities. The EQRO provides ongoing technical support to DMMA in the development of oversight monitoring strategies to ensure the Medicaid leadership stay informed on new state and federal requirements and the evolving technologies for quality measurement and reporting. Additionally, the DMMA conducts a formal annual evaluation of the QMS to assess the overall effectiveness of the QMS and determine whether demonstrated improvement in the quality of services provided to members, providers, and integrated stakeholders was accomplished. The annual evaluation includes an assessment of:

- The effectiveness of quality interventions and remediation strategies made during the previous year (demonstrated improvements in care and services) and trending of indicator data.
- The appropriateness of the program structure, processes and objectives.
- Identification of program limitations.
- The evaluation of all internal activities to include: quality improvement committees, task forces, advocacy groups, and work groups; complaint, grievance and appeals; and provider complaints and issues.
- Feedback obtained from the Medicaid leadership team and Medical Care Advisory Committee (MCAC) – which also includes feedback from the provider community,

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advocacy, and CMS participants throughout the year regarding the State’s quality management activities;

- Recommendations for enhanced goals and objectives for the upcoming year.

The DMMA and its EQRO reassess and update the QMS as needed based on the activities described above. The updated strategy is simultaneously reviewed by the QII task force, MCAC, advocacy groups, and internal and external stakeholders involved in the program. Each entity provides feedback and recommendations to the QMS to enhance strategies and establish goals and objectives for the following year. Once input is received and consensus is made by all stakeholders, the QMS is finalized and shared with the QII Task Force, DSAAPD QIC, DLTCRP, DPH and other key stakeholders (e.g., agency directors) involved in the program.

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Attachment to H1 : Delaware’s ABI Waiver Assurance Monitoring & Reporting Strategy

Note: please see notes and acronyms at the end of this section prior to reviewing this document.

Assurance Requirement	Monitoring Strategy	Accountability	Data Sources	Frequency
Assurance: H.1.a.: Level of Care (LOC) Determination				
HCBS Quality Framework Focus:				
<ul style="list-style-type: none"> Participant Access 				
An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.	Conduct comprehensive assessment and determine LOC on each applicant at referral.	DSAAPD	Review of LOC determinations	Daily
	Review of LOC determination for accurate application and completeness of LOC criteria.	DSAAPD	Review of LOC determinations	Daily
	Review of participant record. QII Task Force review of monitoring and reporting quarterly reports from QIC.	DMMA	Review of LOC determinations	Quarterly*
	DMMA Service Delivery Section annual LOC review of 25% of determinations and re-determinations.	DMMA*	Retrospective Review of 25% of Assessments and Case Records.	Annual
The LOC of enrolled participants are reevaluated at least annually or as specified in the approved waiver.	Conduct comprehensive assessment and re-determine LOC on each applicant at least annually.	DSAAPD	<ul style="list-style-type: none"> Retrospective Review of 25% of Assessments and Case Records. LOC Tracking Report 	Ongoing
	Review of LOC determinations for accurate application and completeness of LOC criteria.	DSAAPD	Review of all Assessments by Nursing Supervisors	Ongoing
	Review of participant record. QII Task Force review of monitoring and reporting quarterly reports from QIC.	DMMA*	QIC Quarterly Reports	Quarterly*
	DMMA Service Delivery Section annual LOC review of	DMMA*	Review of 25% of Assessments and Case	Annually

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	25% of determinations and re-determinations.		Records.	
The processes and instruments described in the approved waiver are applied to determine LOC.	Review of participant record. QII Task Force review of monitoring and reporting quarterly reports from QIC.	DSAAPD	Retrospective Review of 25% of Assessments and Case Records.	Monthly
	DMMA Service Delivery Section annual LOC review of 25% all determinations and re-determinations.	DMMA*	Retrospective Review of 25% of Assessments and Case Records.	Annually
The state monitors LOC decisions and takes action to address inappropriate LOC Determinations.	Review of LOC determination for accurate application and completeness of criteria.	DSAAPD	DSAAPD Nursing Supervisor Review of 100% of LOC Initial and Re-determinations	Ongoing
	Review of participant record.	DSAAPD	Retrospective Review of Reasons for Withdrawal and 25% Sampling of those Records.	Annually
	Review of records of participants who have been denied a LOC or withdrew from the program.	DSAAPD	Retrospective Review of Reasons for Withdrawal and 25% Sampling of those Records.	Annually
	Review of state hearing data. QII Task Force review of monitoring and reporting quarterly reports from QIC.	DSAAPD	Retrospective Review of State Hearing Data.	Ongoing
	DMMA Service Delivery Section annual LOC review of all determinations and re-determinations.	DMMA*	Retrospective Review of 25% of All initial and Re-determinations	Annually
Assurance: H.1.b.: Service Plan (aka ABI Care Plans) HCBS Quality Framework Focus: <ul style="list-style-type: none"> • Participant-Centered Service Planning and Delivery • Participant Rights and Responsibilities 				

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Assurance Requirement	Monitoring Strategy	Accountability	Data Sources	Frequency
• Participant Outcomes and Satisfaction				
Service Plans (aka ABI Care Plans) address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.	ABI Care Plans developed by Case Managers.	Case Managers	ABI Care Plans in Case Files	Ongoing
	100% of ABI Care Plans are reviewed and approved by DSAAPD Nurses for completeness and appropriateness.	DSAAPD Nurses	ABI Care Plans in case files	Ongoing
	DSAAPD nursing supervisors review 100% of all newly opened cases including completion of the Awareness Form Title XIX which documents Freedom of Choice (for services and providers) communication to the participant.	DSAAPD Nursing Supervisors	Case Files	Ongoing
	Review Assisted Living (AL) facility participant chart for ABI Care Plan compliance	Case Managers	<ul style="list-style-type: none"> • AL facility Participant's Chart • ABI Care Plan 	Ongoing
	Review Assisted Living (AL) facility participant chart for ABI Care Plan compliance	DSAAPD Nurses	<ul style="list-style-type: none"> • AL facility Participant's Chart • ABI Care Plan 	Quarterly
	Review contracted case management ABI Care Plan documentation for Care Plan compliance.	DSAAPD Nurses	ABI Care Plan in Case Files	Ongoing
	DMMA annual service plan review of 25% sampling of initial and annually updated ABI Care Plans	DMMA Service Delivery Section*	ABI Care Plans in Case Files	Quarterly
The state monitors service plan development in accordance with its policies and procedures and takes appropriate action	DSAAPD nurses' review of 100% of initial and annually updated ABI Care Plans.	DSAAPD Nurses	ABI Care Plans Developed by Case Managers	Ongoing

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when it identifies inadequacies in service plan development.	AL facility ABI Care Plan review.	<ul style="list-style-type: none"> AL facility DLTCRP 	ABI Care Plan Tracking Reports	<ul style="list-style-type: none"> Ongoing Annual
	Waiver service providers' service plans reviews	Case Managers	Service Provider Service Plans	Ongoing
	QII Task Force review of monitoring and reporting quarterly reports from QIC.	<ul style="list-style-type: none"> DSAAPD DMMA 	ABI Care Plan Tracking Reports	Quarterly
	DMMA annual service plan review of 25% of initial and annually updated ABI Care Plans	<ul style="list-style-type: none"> DMMA Service Delivery Section* 	ABI Care Plans in Case Files	Annually
Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.	Contracted Case Manager updates ABI Care Plan after hospitalization/nursing home stay or major health change.	DSAAPD Nurse Case Manager	DSSAPD Case Files	Ongoing
	AL facility updates service plan following major health change.	AL facility DLTCRP/OSO	AL Facility Participant Chart	Ongoing
	QII Task Force review of monitoring and reporting quarterly reports from QIC.	DMMA	DSAAPD QII Quarterly Reports	Ongoing
	DMMA Service Delivery Section annual service plan review of 25% sampling of all initial and updated ABI Care Plans	DMMA	DSAAPD Case Files	Ongoing
Services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan.	Case Managers' ongoing monitoring and review of their clients' ABI Care Plan.	Contracted Case Manager	AL Service Plan Tracking Report	Quarterly
	AL facility/ DLTCRP/	AL facility	ABI Care Plan	Quarterly

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	DSAAPD Nurses service plan monitoring chart review.	DLTCRP DSAAPD Nurses	Tracking Report	
	QII Task Force review of monitoring and reporting quarterly reports from QIC.	DMMA	QIC Quarterly Reports	Quarterly
	DMMA Service Delivery Section annual care plan review of 25% sampling of initial and updated ABI Care Plans	DMMA	ABI Care Plans in Case Files	Annually
Participants are afforded choice: <ul style="list-style-type: none"> • Between waiver services and institutional care; and • Between/among waiver services and providers. 	ABI Care Plans developed by Case Managers.	Case Managers	ABI Care Plans in case files	Ongoing
	100% of ABI Care Plans are reviewed and approved by DSAAPD nurses for completeness and appropriateness.	DSAAPD Nurses	ABI Care Plans in case files	Ongoing
	DSAAPD Nursing Supervisors review 100% of all newly opened cases including completion of the Awareness Form Title XIX which documents Freedom of Choice (for services and providers) communication to the participant.	DSAAPD	Case Files	Ongoing
	Review AL facility participant chart for service plan compliance.	<ul style="list-style-type: none"> • AL facility • DSAAPD Nurses. • Case Managers 	<ul style="list-style-type: none"> • AL Facility Participant Charts. • ABI Care Plan 	<ul style="list-style-type: none"> • Ongoing • Quarterly • Ongoing
	Review Contracted Case Management ABI Care Plan documentation for ABI Care Plan compliance.	DSAAPD Nurses	ABI Care Plans in case files.	Ongoing
	DMMA annual ABI Care Plan review of 25% of all initial and updated ABI Care Plans.	DMMA*	ABI Care Plans in case files.	Annually

Assurance: H.1.c.: Qualified Providers

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HCBS Quality Framework Focus:				
• Provider Capacity and Capabilities				
The state verifies that providers meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.	Provider annual licensure/re-licensure/credentialing reporting	<ul style="list-style-type: none"> • DSAAPD • DLTCRP • DPH 	<ul style="list-style-type: none"> • DLTCRP Annual Site Visit Survey Instrument and Reporting. • DPH Initial and Re-licensure Survey/Review Reporting • Tracking, Monitoring and Reporting Analyses Across Licensure Agencies/ Departments Collected by DSAAPD Waiver Coordinator 	Annual
	Obtain documentation of provider licensure or certification.	<ul style="list-style-type: none"> • DLTCRP • DMMA/Provider Relations Agent • DPH 	Tracking, Monitoring and Reporting Analyses Across Licensure Agencies/ Departments Collected by DSAAPD Waiver Coordinator	Annual
	Review provider capacity.	<ul style="list-style-type: none"> • DSAAPD 	<ul style="list-style-type: none"> • DLTCRP Annual Site Visit Survey Instrument and Reporting. • DPH Initial and Re-licensure Survey/Review Reporting • Case Management and Nursing 	<ul style="list-style-type: none"> • Annual • Annual • Quarterly and On As

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			Resident and Provider Monitoring Reports.	Needed Basis
	If applicable, any safe designated area for people with memory impairment to prevent wandering away from safety.	<ul style="list-style-type: none"> • DLTCRP • DPH 	Tracking, Monitoring and Reporting Analyses Across Licensure Agencies/ Departments Collected by DSAAPD Waiver Coordinator	Quarterly and On As Needed Basis
	AL inspection summaries and compliance history information posted in public places.	<ul style="list-style-type: none"> • DLTCRP 	Tracking, Monitoring and Reporting Analyses Across Licensure Agencies/ Departments Collected by DSAAPD Waiver Coordinator	Quarterly and On As Needed Basis
	Results from complaint monitoring, on-site surveys, and provider and participant satisfaction surveys are summarized and analyzed for trends.	<ul style="list-style-type: none"> • DMMA/ Provider Relations Agent** • DSAAPD • DLTCRP • DPH 	Tracking, Monitoring and Reporting Analyses Across Licensure Agencies/ Departments Collected by DSAAPD Waiver Coordinator	Quarterly
The state verifies on a periodic basis that providers continue to meet required licensure and/or certification standards and/or adhere to other state standards.	AL, Adult Day Care Providers, Home Health	<ul style="list-style-type: none"> • DMMA/ Provider Relations Agent** • DLTCRP • DPH 	<ul style="list-style-type: none"> • DLTCRP Annual Site Visit Survey Instrument and Reporting. • Case Management and Nursing Resident and Provider Monitoring Reports. • Tracking, Monitoring and Reporting Analyses 	<ul style="list-style-type: none"> • Annual • Quarterly and On As Needed Basis • Quarterly

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			Across Licensure Agencies/Departments Collected by DSAAPD Waiver Coordinator	
	Annual site visit survey of facilities/providers.	<ul style="list-style-type: none"> DLTCRP DPH 	Tracking, Monitoring and Reporting Analyses Across Licensure Agencies/ Departments Collected by DSAAPD Waiver Coordinator	Quarterly
	Obtain documentation of provider licensure or certification.	<ul style="list-style-type: none"> DLTCRP DPH DMMA/ Provider Relations Agent** 	Tracking, Monitoring and Reporting Analyses Across Licensure Agencies/ Departments Collected by DSAAPD Waiver Coordinator	Quarterly
	Review provider capacity.	<ul style="list-style-type: none"> DSAAPD DLTCRP DPH 	Tracking, Monitoring and Reporting Analyses Across Licensure Agencies/ Departments Collected by DSAAPD Waiver Coordinator	Quarterly
	If applicable, any safe designated area for people with memory impairment to prevent wandering away from safety.	<ul style="list-style-type: none"> DLTCRP DPH 	Tracking, Monitoring and Reporting Analyses Across Licensure Agencies/ Departments Collected by DSAAPD Waiver Coordinator	Quarterly
	AL inspection summaries and compliance history information posted in public places.	DLTCRP	DLTCRP Annual Site Visit Survey Instrument and	Annual

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Assurance Requirement	Monitoring Strategy	Accountability	Data Sources	Frequency
			Reporting.	
	Results from complaint monitoring, on-site surveys, and provider and participant satisfaction surveys are summarized and analyzed for trends	<ul style="list-style-type: none"> • DSAAPD • DLTCRP • DPH 	Tracking, Monitoring and Reporting Analyses Across Licensure Agencies/ Departments Collected by DSAAPD Waiver Coordinator	Quarterly
	DMMA provides EDS with the general policy and procedures for “other” service provider to meet. Once EDS has that in hand they will review all applications against the policy.	DMMA/Provider Relations Agent**	Tracking, Monitoring and Reporting Analyses Across Licensure Agencies/ Departments Collected by DSAAPD Waiver Coordinator	Quarterly
The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.	DMMA’s Provider Relations Agent monitors waiver providers to assure compliance with the requirements identified in the waiver service specifications	DMMA/Provider Relations Agent**	Annual contract Update Requests to Each Provider for Contract Documentation Requirements	Annually
The state identifies and remediates situations where providers do not meet requirements.	State Agencies and Provider Relations Agent monitors credentials and CMS records for fraud and abuse.	<ul style="list-style-type: none"> • DMMA/Provider Relations Agent** • DLTCRP • DPH 	Audits	Annually and On As Needed Basis
The state implements its policies and procedures for verifying that provider training has been conducted in accordance with state requirements and the approved waiver.	<ul style="list-style-type: none"> • AL and other ABI providers possess appropriate skills, competencies, and certification. • AL provider has an emergency preparedness plan. • DSAAPD Community Service Program (CSP) staff possess appropriate skills and competencies. 	<ul style="list-style-type: none"> • DLTCRP • DSAAPD • DPH 	<ul style="list-style-type: none"> • DLTCRP Annual Site Visit Survey Instrument and Reporting. • Case Management and Nursing Participant and Provider Monitoring Reports. • DPH Licensure Renewal 	<ul style="list-style-type: none"> • Annual • Quarterly and On As Needed Basis. • Annual

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			Documentation and Reporting	
Assurance: H.1.d.: Health and Welfare HCBS Quality Framework Focus: <ul style="list-style-type: none"> • Participant Safeguards • Participant Outcomes and Satisfaction 				
There is continuous monitoring of the health and welfare of waiver participants and remediation actions are initiated when appropriate.	<ul style="list-style-type: none"> • Annual site visit survey of facilities/providers. • Review provider certification. 	<ul style="list-style-type: none"> • DLTCRP • DSAAPD - APS • DPH 	<ul style="list-style-type: none"> • DLTCRP annual site visit survey instrument and reporting. • DPH initial and annual site visits and re-licensing processes 	Annual
	<ul style="list-style-type: none"> • Review provider capacity. • Review of Case Management ABI Care Plans. • Documentation of medication regimen. • Staff certification. 	<ul style="list-style-type: none"> • DLTCRP • DSAAPD • DPH 	<ul style="list-style-type: none"> • Case Management and Nursing Resident and Provider Monitoring Reports. 	Quarterly and On As Needed Basis
	<ul style="list-style-type: none"> • Results from complaint monitoring, on-site surveys, and provider and participant satisfaction surveys are summarized and analyzed for trends. 	<ul style="list-style-type: none"> • DSAAPD 	<ul style="list-style-type: none"> • Participant satisfaction surveys conducted by OSO. • Data and tracking analysis. 	<ul style="list-style-type: none"> • At the Conclusion of Each Investigation • Quarterly
The state, on an on-going basis, identifies and addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.	<ul style="list-style-type: none"> • Resident has access to OSO and DLTCRP for reporting incidents. • Resident is presented with information at admission about provider services, and resident rights. • Review of resident 	<ul style="list-style-type: none"> • DLTCRP • DSAAPD • DSAAPD - APS • DPH 	<ul style="list-style-type: none"> • Survey instrument and reports. • Case Management and Nursing Resident and Provider Monitoring Reports. 	Annual and On As Needed Basis

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	agreement and contract for compliance with admission protocol.		<ul style="list-style-type: none"> Resident records. AL provider records. 	
	<ul style="list-style-type: none"> Reporting and monitoring of DLTCRP survey results and facility monitoring efforts. 	<ul style="list-style-type: none"> DSAAPD DSAAPD - OSO DMMA - QII 	Monthly monitoring reports and results.	Monthly
	<ul style="list-style-type: none"> Analyze incident data and report to QII and QIC. 	<ul style="list-style-type: none"> DSAAPD DSAAPD - OSO DSAAPD - APS DPH 	<ul style="list-style-type: none"> Incident data from DLTCRP. Incident data from OSO production System. 	Monthly
Assurance: H.1.e.: Administrative Authority HCBS Quality Framework Focus: <ul style="list-style-type: none"> System Performance 				
The Medicaid agency retains ultimate authority and responsibility for the operation of the waiver by exercising oversight over the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities	SUR peer ranking of all providers.	DMMA	SUR subsystem	Quarterly
	LOC and Service Plan audits.	DMMA*	Case Files at DSAAPD offices	Annually
	DMMA QII (Quality Initiatives Improvement Task Force) Monitoring and Reporting	DMMA	QIC Quarterly Reports	Quarterly
	DSAAPD QIC (Quality Improvement Committee) Monitoring and Reporting.	DSAAPD	Monitoring and reporting to DMMA Leadership and Medical Care Advisory Committee	Monthly and Quarterly
	Results from complaint monitoring, on-site surveys, and provider and participant satisfaction surveys are summarized and analyzed for	DSAAPD Waiver Coordinator	Monitoring and Reporting Monthly Analysis and Reports.	Monthly

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Assurance Requirement	Monitoring Strategy	Accountability	Data Sources	Frequency
	trends.			
H.1.f.: Financial Accountability				
HCBS Quality Framework Focus:				
<ul style="list-style-type: none"> System Performance 				
Claims for Federal financial participation in the costs of waiver services are based on state payments for waiver services that have been rendered to waiver participants, authorized in the service plan, and properly billed by qualified waiver providers in accordance with the approved waiver.	MMIS financial and utilization reporting.	DMMA	MMIS management reports.	Monthly
	SUR peer ranking of all providers.	DMMA	SUR subsystem and provider audits.	Monthly
	Claims Processing Assessment for ABI Providers.	DMMA	MMIS – Claims Processing Assessment System.	Ongoing
	Monthly reporting and monitoring of case management service authorizations, utilization, and claims costs.	DMMA DSAAPD	MMIS management reports	Monthly
	Periodic onsite audits of charts (selected through random sampling of claims) at providers offices.	DSAAPD	MMIS – Claims Processing Assessment System. MMIS management reports	Ongoing

Notes

* = DMMA will audit a 25% sample of LOC and Case Management ABI Care Plans on an annual basis through its Service Delivery Section at the DSAAPD offices.

** = DMMA contracts with the provider relations agent to provide MMIS system and reporting technical support.

Acronyms

- DMMA – Division of Medicaid and Medical Assistance
- DSAAPD – Division of Services for Aging and Adults with Physical Disabilities
- OSO - Ombudsman
- QII – Quality Initiative Improvement Committee: Medicaid’s Quality Management System strategy development and ongoing infrastructure for ensuring oversight and integration of the waivers’ quality strategy with Medicaid’s overall strategy.
- QIC – Quality Improvement Committee: DSAAPD’s quality committee responsible for the division’s quality management strategy for all of the waivers operated within the division

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Appendix I: Financial Accountability

APPENDIX 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 that are 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 ABI waiver. DMMA has responsibility for oversight of ABI 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) which is 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 ABI waiver must be prior authorized by the case manager. The prior authorization number will be 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 will be rejected. Two new Eligibility Aid Categories will be established to identify ABI waiver clients in the MMIS so that edits can be established to limit claims for waiver services to individuals who are eligible for the ABI waiver. Edits will also be established to enforce unit or other limitations for individual services in addition to the system requirement for prior authorization. For instance, an edit will be established to prevent claims for certain services from being paid while an ABI waiver client is an Assisted Living Facility, where the other service being billed is assumed to be included in the Assisted Living facility payment. Additionally, contracted case managers are responsible for monitoring the receipt of services under the ABI 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, the agency that is actually administering the waiver, DSAAPD will conduct 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,

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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. ABI 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 Auditors 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.

As outlined in the EDS Provider Policy Manual, section 1.36, DMMA requires any provider who has received \$10,000 or more in payments from medical assistance funds in any quarter to submit a Medicaid Credit Balance Report (MCBR). This process is another tool to identify overpayments to a provider and/or instances where Medicaid was not the payer of last resort, as required. The provider must submit the report, along with a certification, regardless of whether or not any monies are owed (i.e. no Medicaid balance). Failure to follow the procedures required in this process causes the MMIS to suspend any future claims submitted by that provider until the requirements of the MCBR are met.

The standard Medicaid Provider Contract 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 will require 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 will ensure that the appropriate documents are received and reviewed annually.

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APPENDIX I-2: Rates, Billing and Claims

- 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 ABI waiver is to be operated by the Division of Service for Aging and Adults with Physical Disabilities (DSAAPD) and the state share for claims for these services will come from DSAAPD's budget, DSAAPD will set the rates for ABI waiver services. DMMA will provide oversight and technical assistance in the rate setting process. These responsibilities are outlined in an MOU between the two divisions.

Unless otherwise stated, the rates for services below were originally set some years ago by analyzing provider costs. In subsequent years these rates were inflated in attempts to keep up with rising expenses. Any enhancement of rates must first be matched against the availability of budgeted funds.

NOTE: 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 where the projected impact of calculated increases applied to anticipated utilization would exceed the state waiver budget, rate increases will be capped at the budgeted amount.

Waiver Service (WS) – Case Management – For the purposes of the financial calculations in Appendix J, a rate of \$200/month was used. In order to validate this rate, a survey of the 12 states with brain injury waivers was conducted. This rate is within the range of rates paid for case management services by other states that have brain injury waivers.

Assisted Living - Room and board is not included in the AL rate. AL is broken down into two sub-levels (below).

WS – Assisted Living (Level I - Basic) – The rate methodology already approved under Delaware's 1915(c) Assisted Living Waiver will be used. The rate methodology developed for the present Assisted Living waiver managed by DSAAPD results in a per diem rate and was originally based on provider cost reports inflated over time. Activities and their related costs are defined as either primary (nursing care) or secondary patient care (other patient care as defined in the methodology). This distinction is made because primary care costs are not capped, whereas caps are applied to the secondary care costs.

WS – Assisted Living (Level II - Enhanced for ABI)

For the purposes of the financial calculations in Appendix J, the highest present per diem AL rate was increased by 15 % for the enhanced level of assisted living under the ABI waiver. This enhanced payment is intended to cover the added costs of the provider related to special accommodations that must be made for brain injured clients.

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Adult Day Services - Is broken down into two sub-levels (below).

WS – Level I - Basic Adult Day Services - This is a service presently provided under the Elderly and Disabled 1915(c) waiver also administered by DSAAPD. The rates for this service were initially based on reported provider costs and have been inflated ever since as budgetary constraints have allowed. For the purposes of the financial calculations in Appendix J, the present rates paid for the E&D waiver were inflated slightly (i.e. \$79.11 per day).

WS – Level II – Enhanced (ABI) Adult Day Services - This is an enhanced Adult Day service for which no rate currently exists. Clients evaluated as requiring this enhanced level of service will require more provider resources than Level I Adult Day Services. Therefore, for the purposes of the financial calculations in Appendix J, the Basic Level I rate of \$79.11 per day was increased to \$100 per day.

WS – Day Habilitation - This is a new service for which no previous rate exists. For the purposes of the financial calculations in Appendix J the Level I Adult Day Services rate of \$79.11 was used because the cost of this service is comparable to Adult Day Services (\$79.11 per day). Adult Day Services and Day Habilitation have similar service structures and provider networks.

Cognitive Therapy – Consists of two (2) components (below)

WS – Diagnostic Session - Under the waiver, a multi-disciplinary assessment will be performed at intake and again at each 12 month interval. A rate for this service was derived using data collected by the Delaware Division of Child Mental Health which canvassed other states as well as entities within Delaware to compare its rates of payments for specified mental health services to those of other payers. Based on that data, a rate of \$230/assessment was used for calculations in Appendix J.

WS – Counseling and Therapy – Individual / Group / Family - A rate for these services was derived using data collected by the Delaware Division of Child Mental Health which canvassed other states as well as entities within Delaware to compare its rates of payments for specified mental health services to those of other payers. Based on that data, an average rate of \$120/hour was used calculations in Appendix J. Actual rates of payment will vary based on the level of mental health professional providing the service and whether the session is with the individual, family or a group.

WS – Personal Care Services - This is a service presently provided under the Elderly and Disabled 1915(c) waiver administered by DSAAPD. The rates for this service were initially based on provider usual and customary charges and have been inflated ever since as budgetary constraints have allowed. For the purposes of the financial calculations in Appendix J, the weighted average of the rates paid in FFY 2006 was used \$7.68 per ¼ hr

Respite Care Services - Consists of two (2) components (below)

WS – Respite Care at ¼ Hour Rate - This is a service presently provided under the Elderly and Disabled 1915(c) waiver managed by DSAAPD. The rates for this service were initially based on reported provider costs and have been inflated over time as budgetary constraints have allowed. For the purposes of the financial calculations in Appendix J, the weighted average of the ¼ hour rates paid in FFY 2006 was used (\$6.67).

WS – Personal Emergency Response System - This is a service presently provided under the Elderly and Disabled 1915(c) waiver managed by DSAAPD. The rate is the market rate for these

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services, paid by the month with a service initiation/installation fee. For the purposes of the financial calculations in Appendix J, the weighted average of the daily rates with the initial fee prorated across the 12 months was used (\$31.23).

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 the ABI waiver services will be 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.

c. Certifying Public Expenditures (select one):

<input type="radio"/>	Yes. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (<i>check each that applies</i>):
<input type="checkbox"/>	Certified Public Expenditures (CPE) of State Public Agencies. Specify: (a) the public 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). (<i>Indicate source of revenue for CPEs in Item I-4-a.</i>)
<input type="checkbox"/>	Certified Public Expenditures (CPE) of Non-State Public Agencies. Specify: (a) the non-State public 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). (<i>Indicate source of revenue for CPEs in Item I-4-b.</i>)
<input checked="" type="checkbox"/>	No. Public agencies do not certify expenditures for waiver services.

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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. Applicants who meet both criteria are referred to DSAAPD for further screening to determine whether they are appropriate for the ABI Waiver. If they are accepted into the waiver, they are assigned one of two Eligibility Aid Categories that are unique to the ABI waiver. These Aid Categories will be used by the MMIS during claims processing to determine which claims can be paid, consistent with waiver service limitations and requirements (like prior authorization) that have been programmed into the MMIS. The start and stop dates (if applicable) for the period of time the recipient is eligible for ABI waiver services is part of the eligibility record for each waiver recipient stored in the MMIS.

Once eligible for ABI waiver services, each client will be assigned to a contracted case manager. All ABI waiver services must be prior authorized by the case manager with time or unit limits that are entered into the MMIS. The MMIS will use 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 client’s receipt of services pursuant to the ABI care plan and the resulting prior authorizations. Per the MOU, between DMMA and DSAAPD, DSAAPD will periodically review claims data against plans of care and case manager reports, to monitor over and under utilization of services. DMMA will be responsible for retrospective auditing of paid claims and utilization review of services provided through DSAAPD. This will include at the least: SUR unit review of service utilization and review by the DMMA Service Delivery Section of a sample of Plans of Care and Levels of Care determination.

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

The amount paid on each claim is based on a rate table which, for the ABI waiver, will be 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 clients for whom claims were submitted (which will include ABI clients) to 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 client with dates, provider names and specific procedures which Medicaid has been asked to pay on behalf of that client and asks the client 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 client wishes to make. The client 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).

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- 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 §74.53.

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APPENDIX I-3: Payment

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

<input checked="" type="checkbox"/>	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
<input type="checkbox"/>	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) 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.
<input type="checkbox"/>	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:
<input type="checkbox"/>	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:

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*):

<input checked="" type="checkbox"/>	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
<input type="checkbox"/>	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:
<input type="checkbox"/>	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.

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

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financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

<input checked="" type="checkbox"/>	No. The State does not make supplemental or enhanced payments for waiver services.
<input type="checkbox"/>	<p>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 and (b) the types of providers to which such payments are made. 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.</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>

d. Payments to Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

<input checked="" type="checkbox"/>	<p>Yes. Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. <i>Complete item I-3-e.</i></p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
<input type="checkbox"/>	<p>No. Public providers do not receive payment for waiver services. <i>Do not complete Item I-3-e.</i></p>

e. Amount of Payment to Public Providers. *Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:*

<input checked="" type="checkbox"/>	The amount paid to public providers is the same as the amount paid to private providers of the same service.
<input type="checkbox"/>	The amount paid to public 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.
<input type="checkbox"/>	<p>The amount paid to public providers differs from the amount paid to private providers of the same service. When a public 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:</p> <div style="border: 1px solid black; height: 60px; width: 100%;"></div>

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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:*

<input checked="" type="checkbox"/>	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
<input type="checkbox"/>	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
<input type="checkbox"/>	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.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

<input type="checkbox"/>	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.
<input checked="" type="checkbox"/>	No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

<input type="checkbox"/>	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:
<input checked="" type="checkbox"/>	No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

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iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

<input type="radio"/>	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 <i>voluntarily</i> elect to receive <i>waiver</i> 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.
<input type="radio"/>	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain <i>waiver</i> 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.
<input checked="" type="checkbox"/>	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

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APPENDIX I-4: Non-Federal Matching Funds

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. *Check each that applies:*

<input checked="" type="checkbox"/>	Appropriation of State Tax Revenues to the State Medicaid agency
<input type="checkbox"/>	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 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 public agencies as CPEs, as indicated in Item I-2-c:
<input type="checkbox"/>	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 public agencies as CPEs, as indicated in Item I-2- c:

b. Local 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. *Check each that applies:*

<input type="checkbox"/>	Appropriation of Local Revenues. Specify: (a) the local 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 public agencies as CPEs, as specified in Item I-2- c:
<input type="checkbox"/>	Other non-State Level Source(s) of Funds. Specify: (a) the source of funds; (b) the 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 public agencies as CPEs, as specified in Item I-2- c:
<input checked="" type="checkbox"/>	Not Applicable. There are no non-State level sources of funds for the non-federal share.

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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) provider taxes or fees; (b) provider donations; and/or, (c) federal funds (other than FFP). *Select one:*

<input checked="" type="checkbox"/>	None of the specified sources of funds contribute to the non-federal share of computable waiver costs.
<input type="checkbox"/>	The following source (s) are used. <i>Check each that applies.</i>
<input type="checkbox"/>	Provider taxes or fees
<input type="checkbox"/>	Provider donations
<input type="checkbox"/>	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:

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APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

<input type="radio"/>	No services under this waiver are furnished in residential settings other than the private residence of the individual. <i>(Do not complete Item I-5-b).</i>
<input checked="" type="checkbox"/>	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. <i>(Complete Item I-5-b)</i>

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:

ABI Waiver participants in assisted living will, of course, be living in a facility as opposed to a personal residence. Assisted living providers will receive per diem payment for needed non-room and board services provided to the client. The Assisted Living rate setting methodology used by DSAAPD for the Assisted Living Waiver includes only those provider costs which are related to health maintenance (basic nursing care, clinical consultants, social services, dietitian services and activity therapy, etc.). This same rate setting methodology will also be used for the basic per diem rate for Assisted Living services for the new ABI waiver. Patient pay amounts are assessed and will be used to cover the room and board costs in Assisted Living Facilities as is currently done under the approved Assisted Living Waiver. The determination of room and board payments is based upon the SSI Federal Benefit Rate which is adjusted each calendar year for cost of living allowances. For those participants for whom the patient pay is not sufficient to cover the room and board costs, state-only funds can be used to supplement the payment to the facility up to the room and board amount. No federal matching funds are claimed for those expenditures and they are not paid via the MMIS.

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APPENDIX 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:

<input type="radio"/>	<p>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. <i>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:</i></p> <div style="border: 1px solid black; height: 50px; background-color: #e0e0e0; margin-top: 5px;"></div>
<input checked="" type="checkbox"/>	<p>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.</p>

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APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

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:*

<input checked="" type="checkbox"/>	No. The State does not impose a co-payment or similar charge upon participants for waiver services. <i>(Do not complete the remaining items; proceed to Item I-7-b).</i>
<input type="checkbox"/>	Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services. <i>(Complete the remaining items)</i>

i. Co-Pay Arrangement Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies):*

<i>Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):</i>	
<input type="checkbox"/>	Nominal deductible
<input type="checkbox"/>	Coinsurance
<input type="checkbox"/>	Co-Payment
<input type="checkbox"/>	Other charge <i>(specify):</i>

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Amount of Charge	Basis of the Charge

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iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant (*select one*):

<input type="radio"/>	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
<input type="radio"/>	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. The State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one*:

<input checked="" type="checkbox"/>	No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
<input type="radio"/>	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:

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Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care (<i>specify</i>):							
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 (Column 7 less Column 4)
1	\$35,612	\$7,098	\$42,710	\$75,486	\$3,937	\$79,423	\$36,713
2	\$36,663	\$7,325	\$43,998	\$77,902	\$4,063	\$81,965	\$37,977
3	\$37,958	\$7,589	\$45,547	\$80,706	\$4,209	\$84,915	\$39,368
4							
5							

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Appendix J-2 - Derivation of Estimates

- a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants			
Waiver Year	Total Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1	50		
Year 2	60		
Year 3	70		
Year 4 (renewal only)			
Year 5 (renewal only)			

- 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-d.

Average length of stay (LOS) for waiver clients is assumed to be 350 days per year. This figure was based on data for existing clients who are currently being served in Delaware’s Assisted Living (AL) and Elderly and Disabled (E&D) HCBS waivers who have been assessed as being able to benefit from ABI services.

Although the average length of stay for these clients can be determined from current data (calculated for CY 2006 at 260 days for AL and 294 days for E&D) it is expected that the LOS for future clients in the ABI waiver will be greater than those of the total AL and E&D waivers for the following reasons. Prospective ABI clients tend to be much younger than the average AL or E&D client. With the exception of their acquired brain injury they also tend to be in good health. Hence, once a client is admitted to the waiver, we expect them to remain eligible for waiver services for many years.

As an example, 14 of the 15 potential ABI waiver clients presently living at the Peachtree Acres AL facility were there the entire year in CY 2006. This resulted in an “average” CY 2006 stay of 345 days for AL waiver clients who have been assessed as suitable for the ABI waiver.

Because turnover in the waiver population is expected to be minimal, the average annual stay is estimated at 350 days (just short of an entire year).

- 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:

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Background

There are three main variables used to estimate the average per client Factor D costs for the waiver services: 1) the estimated number of clients that will utilize each service; 2) the expected average number of units of each service those clients will use; and 3) the estimated cost of each unit of service.

Utilization and cost patterns in the current E&D and AL waivers served as a basis for many of the cost estimates in the ABI waiver. Patterns for the ABI waiver are expected to be comparable to those in these other two waivers, including variations in cost between participants who receive assisted living services and those who do not. The estimated number of participants who will utilize the various services in the ABI waiver is based, in part, on the estimated number of participants in the ABI waiver who will receive assisted living services. (It is estimated that approximately 40% of ABI waiver participants will receive assisted living services, and approximately 60% will not.) This estimate is significant in deriving the cost of services such as personal care, which is a component of the assisted living service in Delaware. Therefore, the personal care services described in Appendix C would not be needed by individuals who are receiving comparable support through their assisted living service providers.

The aforementioned estimated average annual stay of 350 days, or 50 weeks or 12 months was used in the calculation of Factor D.

Service cost estimates

Case Management – All 50 waiver clients will receive case management services each month at an estimated cost of \$200 per month. The \$200 per month figure was determined using rate data canvassed from other states that operate ABI-type waiver programs and that use contracted case managers where a monthly fee is paid. The Delaware rate is within the range of low to high rates based on our understanding of the relationship of the case management functions we will contract for vis a vis what the other states contract for.

$$12 \text{ months} \times 50 \text{ clients} \times \$200 \text{ per month} = \$120,000$$

Assisted Living - From the present dispersion of potential ABI clients among the present E&D and AL waivers, we estimate that 20 of the 50 ABI waiver (40%) clients will reside in assisted living facilities. We estimate an average length of stay of 350 days per year in the AL facility. Each of the ABI clients in an assisted living facility will be assigned into one of two tiers (Level I – Basic or Level II- Enhanced). Each tier will be paid at a different per diem rate. Of the ABI clients to be residing in an assisted living facility, it is estimated 25% will be in the Level I - Basic tier with the remaining 75% being assigned to the Level II - Enhanced tier. The Level I rate was estimated by taking an average of the 2007 per diem rates in the six Assisted Living waiver Levels of Reimbursement (10, 12, 20, 22, 30, 32) and weighting them by the dispersion of potential ABI clients presently in the Assisted Living waiver and residing at Peachtree Acres or clients with similar care needs residing at Stockley Assisted Living. (Note: Stockley will not be a provider under this waiver. Cost data for this client population is used for calculation purposes only.) The Level II rate was estimated as 15% above the highest “regular” 2007 assisted living rate paid under the AL waiver. This enhanced level of payment is necessary to compensate for the additional staff time in the AL facilities that is necessary to manage the more complex needs of certain participants.

Adult Day Services - In the proposed ABI waiver, there are two (2) sub-types of adult day services:

Adult Day Services: Level 1 – Basic Adult Day Services

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- The “regular” program as presently provided under the E&D Waiver
 Adult Day Services: Level 2 - Enhanced Adult Day Services

Day Habilitation

For purposes of budgeting, adult day services (Levels I and II) and day habilitation were considered as a group. This was done because of the similarity of service structures and provider networks. Using CY 2006 claims for E&D waiver claims, we determined that only about 21% of the E&D clients took advantage of the Basic Adult Day Services available and used only an average of under three days per week. However, given that one of the primary functions of the case managers in the ABI waiver is to ensure that clients avail themselves of necessary services, we assume that use of this service will be higher than under the E&D waiver, with 40 of the 50 clients (80%) receiving some type of day programming four days a week for the entire time they are in the waiver. The usage among the three sub-types of day programs is assumed to be weighted heavily towards the new Enhanced ABI Adult Day Services and Day Habilitation, with 18 clients in Enhanced ABI Day, 17 clients in Day Habilitation and only 5 clients in the Basic Adult Day Services. Estimated rates for regular Adult Day Services and Day Habilitation were based on the present rates for regular Adult Day Services paid under the E&D waiver. The rate for Enhanced ABI Day Services is estimated to be \$100 per day (26 % higher than Basic adult day services) based on the additional requirements for ABI waiver clients.

Cognitive Services – This service will have two (2) components:

A) a multi-disciplinary assessment to determine the client’s level of functioning and service needs (performed at intake and again at each 12 month interval that the client remains in the waiver), and

B) behavioral therapies: individual, family and group. We estimate that each client will receive approximately 20 hours of therapy per year.

Estimated rates for these services were based on unit cost data gathered by the Delaware Division of Child Mental Health Services which canvassed other states, as well as other purchasers of mental health services in Delaware regarding unit costs for these types of services.

Respite Care – This service is in home respite care billed at ¼ hour intervals. Based on CY 2006 E&D Waiver claim data, we determined that 13% of E&D clients used the in-home respite care. On average, clients used about 8 units per week. However, given that under the ABI waiver, case managers are expected to encourage a much higher use of day programming, we expect the demand for in-home respite care to decrease (from 8 hrs per week to 6 hrs) for the approximately 30 clients who live outside of assisted living and who we anticipate using this service.

Personal Care - Using CY 2006 E&D waiver claims, we determined that about 85% of the clients utilized personal care services for about 40 ¼ hr units per week.

Personal Emergency Response System – Using CY 2006 E&D waiver claims, we determined that 75% of the clients utilized emergency response services.

Estimates for Years 2 and 3

For the purpose of estimating costs in years 2 and 3, all unit costs were inflated from year 1 to

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year 2 by 3.2% and from year 2 to year 3 by 3.6%. The inflation rates used were the same source as DMMA uses to inflate its prospective nursing facility per diem rates, i.e. Global Insights Forecast Assumptions table for Skilled Nursing Facilities, Quarterly index levels for 2007-Q3, 2008-Q3, and 2009-Q3 from the 3rd quarter 2006 Report.

- 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:

Estimates for Factor D' are based, in part, on utilization patterns of participants in the current E&D and AL waivers. Patterns for the ABI waiver are expected to be comparable, including variations in cost between participants who receive assisted living services, and those who do not. For purposes of cost estimation only, the participants in the ABI waiver are grouped into two populations: those receiving assisted living services, and those not receiving assisted living.

The CMS 372 reports for the present E&D and AL waivers were NOT used in calculating Factor D prime because they include periods of time both pre- and post-implementation of Medicare Part D (1/1/06) and would have required complicated adjustments in order to account for the effects of Part D. Instead, E&D and AL waiver claims data for dates of service in calendar year 2006 were used to compile this estimate of non-waiver costs. Claims data was extracted from the "DE Title XIX Ad Hoc Universe" database, a collection of data tables extracted from the MMIS database each week. In addition, eligibility records for E&D and AL clients were extracted to obtain the total number of "client days" for each of those waivers for CY 2006. Of the total clients in the AL waiver living in an AL facility, 17 clients have brain injuries and were evaluated by DSAAPD as being representative of the ABI waiver population in assisted living facilities. These 17 clients could potentially transfer from the AL waiver to receive assisted living services of the new ABI waiver. Hence, Factor D Prime cost estimates for the assisted living clients of the ABI waiver were determined using CY 2006 claims and eligibility records of those 17 clients and calculating a cost per client per day. Claims for ALL E&D clients were used in the calculation of Factor D prime. Claims in both waivers were "scored" as a Factor D claim (waiver service) or a Factor D Prime claim (regular, State Plan/EPSTDT service). The total paid claims for Factor D Prime claims was determined for each waiver (E&D and the subset of AL). These claim totals were divided by the total number of CY2006 client days for each waiver (total clients for E&D and the 17 targeted clients for AL) to obtain a cost per client per day for each waiver.

The per client/per day costs for those receiving assisted living services and those not receiving assisted living were multiplied by 350 days to obtain an annual base Factor D Prime cost for each group. To each of these base numbers, 12 months of Medicare Part D "clawback" payments (prorated by the estimated percentage of Medicare eligible clients in each ABI track) was added to arrive at a true per client cost for regular State Plan services. An additional estimated cost of \$182.62 was added per person per year for the anticipated increased use of state plan services for physical, occupational, and speech therapies, as case managers will now be available to encourage and arrange use of these and other appropriate services.

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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:

Factor G costs for institutionalized clients are based on payments to skilled and intermediate nursing facilities. Individual per diem rates are calculated annually for each facility for specified Levels of Care. Reimbursement rates are set for each Level of Care to account for difference in the level of facility resources needed for the care of each patient based on level of acuity, diagnosis and service “add-ons. Patient Level of Care is assessed at admission and at each 4 month interval by DMMA nurses.

Each year, after the annual rate calculation, the DMMA Reimbursement Unit creates a table of “Weighted Average Per Diem Rates” nursing facilities (either taxonomy 313M00000X or 314000000X) by the three facility “peer groups” that are used in the rate setting process. Two of the peer groups are determined by geographic boundaries within Delaware (and are currently all privately-operated) and the third is a group of state-operated facilities. The state-operated facility rates are higher because they include ancillary costs that are not included in the per diem rate for the other two peer groups. The per diem rates are weighted by the number of patient days paid at each level of care at each facility to obtain a weighted average for each peer group. A weighted average per diem rate is also calculated for the two private peer groups.

Because waiver clients could potentially be in either a public or private nursing home, where the rates are very different, it was necessary to create a weighted average across all peer groups to estimate the Factor G costs. In order to do this, CY2006 nursing home claims for taxonomies 314000000X or 313M00000X were used to determine the number of patient days paid for clients in the private versus public peer groups. Based on this data, we determined that approximately 12% of the patient days were paid for state-operated facilities and 88% for the two private peer groups.

The most currently available annual weighted average rates available for use in the preparation of this waiver application indicated that the weighted average per diem rate for state facilities is \$341.55 and for private facilities it is \$198.51. Using the 12% state and 88% private split of patient days between the state and private facilities and applying it to the average length of stay (ABI Waiver) of 350 days, the Factor G cost was calculated as follows:
 $(.12 \times 350 \text{ days} \times \$341.55 \text{ per day}) + (.88 \times 350 \text{ days} \times \$198.51 \text{ per day}) = \$75,486.18$

Factor G for year 2 was calculated by inflating the year 1 cost figure by 3.2% and Year 3’s figure was estimated by inflating year 2’s figure by 3.6%. The inflation rates used were the same source as DMMA uses to inflate its prospective nursing facility per diem rates, i.e. Global Insights Forecast Assumptions table for Skilled Nursing Facilities, Quarterly index levels for 2007-Q3, 2008-Q3, and 2009-Q3 from the 3rd quarter 2006 Report.

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:

To estimate Factor G Prime, a multi-step process was used to select claims for clients who received ICF or Skilled level nursing home services for a representative annual period. First, claims for dates of service within CY2006 were selected for clients who had an Aid Category Code in the MMIS indicating the person was institutionalized during the dates of service of the claim. CY2006 was chosen because it is the first full 12 month period under which Medicare Part D was in effect. All claims types were extracted (Drug, Institutional, Professional), including crossover claims. Each claim was “scored” as either a Factor G (i.e. a nursing home or custodial care type facility) or a Factor G Prime (i.e. any claim other than a Factor G).

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Clients were further pared down by selecting only those claims with a taxonomy of a 313M00000X or 314000000X indicating an ICF or SNF nursing facility. This excluded clients in ICF/MR or ICF/IMD facilities, who would not be appropriate for the ABI waiver. Furthermore, claims indicating a super-skilled level of care (Level of Reimbursement codes in the 90 series) were also excluded, as they also would not be an appropriate comparison for ABI waiver clients.

From the remaining client claims, the following data was tabulated: the total number of paid days for CY 2006 for the Factor G claims and the total cost of claims which were scored as Factor G Prime. The cost of Factor G Prime claims was divided by the total number of paid institutional days to arrive at a CY 2006 Factor G Prime cost per day of \$7.51. Multiplying this per day cost by the average length of stay in the ABI waiver of 350 days yields an annual cost per client of \$2,627.13.

In order to fully account for the non-nursing home costs of institutionalized clients, many of whom are eligible for Medicare Part D, the monthly Part D “clawback” payments that the State makes to CMS on behalf of Medicare eligible clients must be added to the Factor G prime, non-institutional costs. Of the clients who were included in the target claims described above that were used to calculate the Factor G cost, approximately 92% were eligible for Medicare during that time period. Therefore, the State would have paid the monthly clawback payment for these persons. The present per client per month clawback payment is \$118.00. In order to add these costs to the Factor G Prime costs, we assumed these monthly payments will have to be paid for 12 months (350 days – 11.5 months) for 92% of the clients. $.92 \times 12 \times \$118 = \$1,302.72$ per client per year. Adding this to the previous Factor G prime figure ($\$2,627.13 + \$1,302.72$), we can calculate the total factor G Prime of \$3,930.

Factor G prime for year 2 was calculated by inflating the year 1 cost figure by 3.2% and Year 3’s figure was estimated by inflating year 2’s figure by 3.6%. The inflation rates used were the same source as DMMA uses to inflate its prospective nursing facility per diem rates, i.e. Global Insights Forecast Assumptions table for Skilled Nursing Facilities, Quarterly index levels for 2007-Q3, 2008-Q3, and 2009-Q3 from the 3rd quarter 2006 Report.

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d. Estimate of Factor D. *Select one:* Note: Selection below is new.

<input checked="" type="checkbox"/>	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
<input type="checkbox"/>	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Case Management	Month	50	12	\$200.00	\$120,000
Assisted Living (per diem)	* See Two Sub-Categories Below				
Level I (Basic)	Day	5	350	\$37.17	\$65,048
Level II (Enhanced)	Day	15	350	\$64.76	\$339,990
Adult Day Services	* See Two Sub-Categories Below				
Level I (Basic)	Day	5	200	\$79.11	\$79,110
Level II (Enhanced)	Day	18	200	\$100.00	\$360,000
Day Habilitation	Day	17	200	\$79.11	\$268,974
Cognitive Services	* See Two Sub-Categories Below				
Multi-Disciplinary Assessment	Each	50	1	\$230.00	\$11,500
Therapies	1 Hr	50	20	\$120.00	\$120,000
Personal Care	¼ Hr	26	2,000	\$7.68	\$399,360
Respite Care	¼ Hr	4	300	\$6.67	\$8,004
Personal Emergency Response System	Month	23	12	\$31.23	\$8,619
GRAND TOTAL:					\$1,780,605
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					50
FACTOR D (Divide grand total by number of participants)					\$35,612
AVERAGE LENGTH OF STAY ON THE WAIVER					350 Days

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Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Case Management	Month	60	12	\$206.40	\$148,608
Assisted Living (per diem)	* See Two Sub-Categories Below				
Level I (Basic)	Day	6	350	\$38.36	\$80,556
Level II (Enhanced)	Day	18	350	\$66.83	\$421,029
Adult Day Services	* See Two Sub-Categories Below				
Level I (Basic)	Day	6	200	\$81.64	\$97,968
Level II (Enhanced)	Day	21	200	\$103.20	\$433,440
Day Habilitation	Day	21	200	\$81.64	\$342,888
Cognitive Services	* See Two Sub-Categories Below				
Multi-Disciplinary Assessment	Each	60	1	\$237.36	\$14,242
Therapies	1 Hr	60	20	\$123.84	\$148,608
Personal Care	¼ Hr	31	2,000	\$7.93	\$491,660
Respite Care	¼ Hr	5	300	\$6.88	\$10,320
Personal Emergency Response System	Month	27	12	\$32.23	\$10,443
GRAND TOTAL:					\$2,199,762
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					60
FACTOR D (Divide grand total by number of participants)					\$36,663
AVERAGE LENGTH OF STAY ON THE WAIVER					350 Days

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Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Case Management	Month	70	12	\$213.83	\$179,617
Assisted Living (per diem)	* See Two Sub-Categories Below				
Level I (Basic)	Day	7	350	\$39.74	\$97,363
Level II (Enhanced)	Day	21	350	\$69.24	\$508,914
Adult Day Services	* See Two Sub-Categories Below				
Level I (Basic)	Day	7	200	\$84.58	\$118,412
Level II (Enhanced)	Day	25	200	\$106.92	\$534,600
Day Habilitation	Day	24	200	\$84.58	\$405,984
Cognitive Services	* See Two Sub-Categories Below				
Multi-Disciplinary Assessment	Each	70	1	\$245.90	\$17,213
Therapies	1 Hr	70	20	\$128.30	\$179,620
Personal Care	¼ Hr	36	2,000	\$8.22	\$591,840
Respite Care	¼ Hr	5	300	\$7.13	\$10,695
Personal Emergency Response System	Month	32	12	\$33.39	\$12,822
GRAND TOTAL:					\$2,657,080
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					70
FACTOR D (Divide grand total by number of participants)					\$37,958
AVERAGE LENGTH OF STAY ON THE WAIVER					350

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