



STATE OF DELAWARE
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MEMORANDUM

DATE: August 29, 2013

TO: Ms. Sharon L. Summers, DMMA
Planning & Policy Development Unit

Ms. Jane Gallivan, Director
Division of Developmental Disabilities Services

FROM: Kyle Hodges, ^{SH}Director
State Council for Persons with Disabilities

RE: 17 DE Reg. 156 [DMMA/DDDS Proposed HCBS Waiver Amendments]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance (DMMA)/Division of Developmental Disabilities Services (DDDS) proposal to adopt some amendments to the current DDDS Medicaid waiver. The changes center on authorizing a new waiver service (“group supported employment”); changing the billable unit for day habilitation, pre-vocational services, and supported employment to 15 minutes; and revising the standards for case manager review of progress on the plan of care. The proposed regulation was published as 17 DE Reg. 156 in the August 1, 2013 issue of the Register of Regulations. SCPD has the following observations.

First, the current “supported employment” definition contains an exclusion for transportation: “Transportation is not included in supported employment services.” At page 158. In contrast, the proposed definitions of individual and group supported employment include transportation as an included expense.¹ At pages 158-159. SCPD strongly endorses this revision.

Second, the State proposes to revamp its standards for case manager monitoring of progress on plans of care. The current standard requires a direct interview with the client every month. The proposed standard requires monthly “paper” monitoring supplemented by a face-to-face direct

¹Transportation costs are also included in rates for day programs and pre-vocational services. See attached p. 153 from “Waiver”.

interview 4 times/year, 2 of which must be in the client's home. At page 159. See also attached page 91 from Waiver. SCPD identified the following concerns in this context.

A. The "Waiver" still contains references to the old standard. See, e.g., attached page 92: "The DDDS Case Manager reviews and monitors the implementation of services at least monthly through a direct, person to person meeting and discussion with the participant."

B. The new standards do not literally permit any flexibility. For example, other sections in the Waiver contemplate updating a plan when the participant's needs change (Waiver, attached pages 85 and 99) and the ELP can require "other progress reports" (Waiver, attached page 91). Literally, a case manager could view the schedule as a rigid "cap" which cannot be exceeded. Thus, there may be circumstances in which more than four (4) face-to-face interviews are needed annually to address a participant's needs. It would be preferable to clarify that the monthly review protocol is a "minimum" which case managers may exceed.

C. It's unclear what documentation would be analyzed by the case manager conducting a monthly "paper" review. Attendance reports may be available on a monthly basis but would not be informative in the context of progress on ELP vocational goals. See attached page 156 from Waiver. The Waiver only contemplates submission of vocational work reports on a quarterly, not a monthly basis. See attached page 91. DHSS could consider either making submission of vocational work reports a monthly requirement or requiring submission of other documentation to allow for meaningful monthly review. For example, Chimes prepares a detailed monthly vocational report. See attached form.

Third, one of the principal rationales for adopting a 15-minute billable unit for day program, pre-vocational services, and supported employment services is flexibility. DDDS wishes to ensure that participants can engage in combinations of supported employment and pre-vocational services. Authorizing billing in small increments facilitates this approach. However, there is some "tension" between this intended flexibility and language in the Waiver itself. Consider the following recitals:

Day Habilitation services can be provided as a full day or hourly. ...Day habilitation may not be provided to a participant during the same hours that Supported Employment, Work Services or Community Inclusion is provided.

Pre-Vocational services can be provided as a full day or hourly. ... Pre-vocational services may not be provided to a participant during the same hours that Supported Employment, Work Services, or Community Inclusion is provided.

Waiver, pages 48 and 50 (attached).

Consider a participant who engages in supported employment between 11-11:30 and pre-vocational services between 11:30-12. Using the 15 minute billing increment, the provider could bill 2 units of supported employment and 2 units of pre-vocational services. However, the above

language would literally bar such billing. Alternatively, consider a participant who engages in supported employment between 9-11:05 and pre-vocational services between 11:05-12:00. The provider could not bill for pre-vocational services for the period 11:05-12:00 since within the same hour as supported employment. For maximum flexibility, the State could consider revising the above “limiting” language and adopting a “quarter hour” unit akin to that used for behavioral consultative services and nursing consultative services. See attached p. 167 from Waiver. See also attached page 153: “Small group will be paid in 15 minute billable units.” It would simply be less confusing to adopt a “quarter hour” standard than to sometimes refer to “hourly” units (page 166) and sometimes refer to “15 minute billable units” (page 153).

Fourth, in a related context, guidance on the 15 minute billable units for behavioral consultative services and nursing consultative services addresses “rounding”:

Units of time 1-8 minutes shall not be billed. Units of time 8-15 minutes shall be billed as one 15 minute unit.

See attached page 154 from Waiver. SCPD could not locate any analog for “rounding” for 15 minute billable units for supported employment, pre-vocational services, and day programming. Clarification would be preferable.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations and recommendations on the proposed regulation.

cc: Mr. Stephen Groff
Mr. Brian Hartman, Esq.
Governor’s Advisory Council for Exceptional Citizens
Developmental Disabilities Council

17reg156 dmma-ddds waiver 8-29-13

EXCERPTS

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

- A. The State of Delaware requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of 1915(c) of the Social Security Act.
- B. Program Title:
Renewal-DDDS Waiver
- C. Waiver Number: DE.0009
Original Base Waiver Number: DE.0009.
- D. Amendment Number:
- E. Proposed Effective Date: (mm/dd/yy)
10/01/13
Approved Effective Date of Waiver being Amended: 07/01/09

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
Delaware wishes to amend the DDDS waiver to make the following changes:

1. Add Supported Employment - Small Group as a waiver service and related provider qualifications and reimbursement methodology. Providers will bill in 15 minute units
2. Revise the service definition of "Supported Employment" to call it "Supported Employment - Individual" and to clarify that the staff to consumer ratio must be 1:1
3. Add service utilization estimates for Supported Employment - Small Group to Appendix J
4. Change the current billable unit for Day Habilitation, Supported Employment - Individual and Pre-vocational service from hourly to 15 minutes
5. Change the frequency of the Case Manager review of the plan of care from a monthly face to face visit with the consumer and their family or guardian to monthly "paper" reviews of the plan with documentation and four face to face visits per year to review the plan with the consumer/family/guardian and revise the related Quality Improvement performance measure.

3. Nature of the Amendment

- A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following

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

Also with the following knowledge, skills, and abilities:

Knowledge of principles, practices, methods and techniques of social work.
 Knowledge of Federal/State eligibility and assistance requirements including Delaware Hospital for the Chronically Ill admission medicare and medicaid.
 Knowledge of agency, hospital, community functions, resources and eligibility requirements.
 Skill in writing, preparing case histories, summaries, logs, reports and records.
 Skill in interviewing applicants and analyzing, assessing and determining needs.
 Skill in counseling clients and establishing effective working relationships with co-professionals.
 Ability to conduct investigations.
 Ability to work in stressful situations.

Verification of Provider Qualifications
Entity Responsible for Verification:
 Division of Developmental Disabilities Services
Frequency of Verification:
 Upon hire and annual performance review

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Service Definition (Scope):

Day Habilitation includes assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services are furnished as specified in the participant's service plan. Day Habilitation services can be provided as a full day or hourly. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Day Habilitation services focus on enabling the participant to attain or maintain his or her maximum functional level in completing activities of daily living and instrumental activities of daily living 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. Day habilitation may not be provided to a participant during the same hours that Supported Employment, Work Services or Community Inclusion is provided.

Transportation to and from the day activity may be provided or arranged by the licensed provider. The licensee shall use the mode of transportation which achieves the least costly, and most appropriate, means of transportation for the individual with priority given to the use of public transportation when applicable and/or appropriate. Transportation expenses are included in the Day Habilitation rate during the initial process of determining an individual rate.

Prevocational Services
Alternate Service Title (if any):

Service Definition (Scope):

Prevocational Services prepare a participant for paid or unpaid employment. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Services are not job-task oriented, but instead, aimed at a generalized result. Services are reflected in the participant's service plan and are directed to habilitative rather than explicit employment objectives. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services are furnished or specified in the participant's service plan. Pre-Vocational services can be provided as a full day or hourly. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

These services also focus on enabling the participant to attain or maintain his or her maximum functional abilities in completing activities of daily living as well as instrumental activities of daily living and shall be coordinated with any physical, occupational, or speech therapies in the service plan. In addition, Prevocational Services may serve to reinforce skills or lessons taught in other settings. Prevocational services may not be provided to a participant during the same hours that Supported Employment, Work Services or Community Inclusion is provided. Transportation expenses are included in the Prevocational services rate during the initial process of determining an individual rate.

Prevocational services are not available under a program under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17)).

Documentation is maintained in the file of each individual receiving this service that the service is not otherwise available under a program funding under the Rehabilitation Act of 1973, or P.L. 94-142.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Prevocational Services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Prevocational Services

Provider Qualifications

the ELP meetings, when and where it is held. All support team members or their designee are requested to attend the Annual ELP meeting unless otherwise requested by the individual receiving services.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Essential Lifestyle Plans are updated, minimally within 365 days of the previous Annual Conference. Plans are updated whenever there is a change in the participant's needs for services and supports.

DDDS attempts to provide information to the person in a way easy to understand so each person is able to make informed choices. DDDS strives to assure during the assessment, plan development, and review/approval processes, the person is assisted by individuals who: know the person well, have demonstrated care and concern for the person, and are trusted by the person.

With this approach, each participant is assisted in selecting a facilitator for his/her ELP development. The facilitator is an individual who has successfully completed the ELP Facilitator Training offered by the DDDS, and who is responsible for putting information learned about a person receiving services into the person's ELP document. Typically this person is the DDDS State Case Manager or a person selected by the individual (See qualifications in section D-1-a.).

The facilitator begins preparing for the ELP development with information the person communicated important to him/her. That information includes the things the person must have, the person's likes & dislikes, their positive attributes, and significant events or accomplishments of the past year.

Included in the ELP development is information identifying how services and supports will enhance the person's life. This information is obtained from a variety of assessment sources including: the Physical Exam Data from the Person's Primary Care Physician, the Comprehensive Medical Evaluation, the IPOP, and the IOSA.

This assessment data, including information about services the participant receives through other state and federal programs is coordinated by the DDDS case manager. The case manager's coordination efforts help to assist the participant with plan development, and to ensure the ELP accurately reflects such services or programs.

All support team members or their designee are invited to attend the Annual ELP meeting unless otherwise requested by the individual receiving services. Issues the person does not wish to discuss at the Annual ELP Meeting, are discussed with appropriate team members and outlined in the final draft of the ELP.

All members of the support team have input and review the Essential Lifestyle Plan prior to implementation. During the meeting, the support team with the input of the person identify and assign responsibilities for implementing (the agency) and monitoring (the state) the plan. Each responsible person is identified in writing, the frequency of monitoring is identified, and the reporting/accountability requirements is identified in the ELP.

Approval of the Essential Lifestyle Plan:

At the end of the ELP document is a section with lines for the signatures of either the agency program coordinator or the DDDS Case Manager who reviewed the plan for technical detail, as well as for inclusion of all participant identified services and supports. Signature space is available for; the participant, the participant's family or guardian, an advocate, the contracted provider, the state Case Manager, the Case Manager Supervisor or the DDDS Regional Program Director, and an advocate as selected by the participant. This inclusive list of signatures constitutes the DDDS system for plan approval.

- Review the participant's progress toward goals stated in the ELP.
- Assess and review the funds of the participant to ensure they are properly managed for the participant's benefit and to maintain waiver eligibility.

During the face to face monitoring of the plan that occurs four times each year, the Case Manager will:

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

If at any point there is belief that a participant's health and welfare is in jeopardy, actions must be taken immediately to assure the person's safety. In a less serious issue, the team will work with the participant, service providers and/or informal supports to address the issue. Depending on the severity and scope of the issue, the State DDDS Case Manager/Agency Program Coordinator may reconvene the planning team to address the issue.

Required Contracted Provider reports of service monitoring are as follows:

- Monthly ELP Progress Report- Completed by the person's Contracted Provider Agency. The Contracted Provider Agency Monthly ELP Progress report looks at identified priority outcome on the ELP Action Plan, and reports on the status of implementation. What is the status of developing the supports for the individual to attain his/her desired outcomes? Is there a concern or problem supporting the person? The Contracted Provider Agency comments as to what actions or steps are taken to support the person's attainment of identified outcomes.
- Monthly Nursing Audit- Completed by the person's identified Registered Nurse. This tool is used to track and monitor all health related services the person receives, as identified on the ELP. The nurse completes the report and provides findings to the provider agency so any corrections or issues needing follow-up may be addressed by the provider agency. Generally, the residential manager and/or the Support Coordinator receive this review through either a Therap report or a hard copy report in the person's record.
- Quarterly Day Service/Vocational/Work Reports- The providers of such services report on the person's progress as related to identified priority outcomes and goals on a quarterly basis. The reports are entered on the Therap system or hard copies are forwarded to the Support Coordinator for inclusion in the person's record.
- Quarterly Behavioral Reports- For persons who have identified behavioral support needs with active plans to address the issues, the Behavior Analyst or Psychological Assistant provide a quarterly data based report on the person's progress. Frequency of reporting may occur at more frequent intervals for person with intensive behavioral support needs.
- Other progress reports are provided as identified and defined in the person's ELP.

Such reports are based upon the person's support needs and identified priority outcomes.

- All reports are designed to assess the quality of the services and supports the individual receives and to stimulate quality improvement activities with each person's priority outcomes as identified on the ELP.
- Each person/discipline providing the service, support, and monitoring activity is required create annual assessment and progress reports and is used by the person and his/her selected support network for subsequent plan development/update activities.
- DDDS and all authorized service providers use T-Logs within the Therap web-based electronic system to document notes regarding contacts with participants, providers, family members and informal supports. All team members must document their communication and actions regarding the waiver participant in Therap.

Office of Quality Management Oversight:

The DDDS Office of Quality Management (OQM) completes Certification of Services reviews for a random sample of participants at the 95% Confidence Level. In addition, the OQM identifies Service Providers and licensed entities that were not captured by the sample selection. For those entities, the OQM completes full certification reviews above and beyond the random sample in order to make evidence based recommendations for contract renewal of all active service providers.

On an annual basis OQM also completes an interview of the providers- the Provider Questionnaire. The results of these three tools are provided to DMMA on an annual basis for the agency to review waiver operations with DDDS.

OQM uses a variety of other review tools in order to assess compliance with applicable standards and regulations. Identified deficiencies in services are identified in order to stimulate agency provided Improvement Plans. In addition the DMMA tools that are reviewed for quarterly trend analysis, the results of the regulation based certification reports are analyzed for identification of systems deficiencies and the development of systemic improvements.

These OQM reports assess Agreements to Participate, Levels of Care, Choice in Selecting Services, and adequacy of services provided. Negative findings from these reports are used to identify deficient practices and to stimulate agency provided improvement plans.

b. Monitoring Safeguards. *Select one:*

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

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

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

The case manager is responsible for service plan development for waiver participants.

In order to ensure the Essential Lifestyle Plan (service plan) monitoring conducted by those furnishing direct services is in the best interest of the waiver participant, the DDDS utilizes a variety of service review processes and sources. As indicated in section D-a-1, the State DDDS Case Manager/Agency Program Coordinator is responsible for the implementation of, and reporting on the status of the services and supports the participant has identified- this includes both waived and non-waived services.

The DDDS Case Manager reviews and monitors the implementation of services at least monthly through a direct, person to person meeting and discussion with the participant. The Case Manager reports findings from review activities to the agency for implementation of Improvement Plans or actions to resolve the participant's concerns.

The DDDS Case Manager's role reflects a position of advocacy for the participant to receive satisfaction with his/her desired and identified outcomes. As there are situations in which the DDDS Case Manager may perform supports or services for the participant- such as to serve as the selected ELP Facilitator- DDDS oversight of services includes additional monitoring safeguards.

Primary system wide monitoring is implemented by the DDDS Office of Quality Management (OQM). The DDDS table of organization was structured for the OQM to report directly to the Division Director, as opposed to the Director of Community Services. Therefore, the OQM is accountable to the Division Director to provide accurate and objective data based performance reviews of waived services and programs.

Administratively, the positioning of the OQM under the Division Director protects the OQM from an alleged conflict of interest in reporting survey results. Were the OQM accountable to report directly to any of the DDDS operational units charged with the responsibility for direct waiver monitoring, then it could pose a concern that hard issues would be avoided and/or glossed over.

The OQM has full access to review all pertinent information related to participant in order to review and assess all services and supports provided for the waiver participants. Level of Care Assessments, Incident Reports (General Event Reports on Therap), Individual Plans of Protective Oversight and Safeguards (IPOPS), Nursing Reports and Essential Lifestyle Plans- including medical/psychiatric and behavioral portions, are examples of reports OQM has access to.

	Ongoing	Specify: _____
	<input type="checkbox"/> Other	Specify: _____

Data Aggregation and Analysis:

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

Performance Measure:

D-c-2: The percentage of Plans of Care indicating services and supports were revised when an individual's needs changed. (The number of Plans of Care indicating services and supports were revised when an individual's needs changed/number of plans reviewed).

Data Source (Select one):

Other

If 'Other' is selected, specify:

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

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

salary expense for the direct care workers providing each type of service. Mercer also reviewed wage data provided by the Bureau of Labor Statistics.

In developing the other three rate components, Mercer first determined the allowable costs to be funded through each service and included only allowable indirect and administrative expenses.

Mercer used this information to develop rates that comply with the requirements of Section 1902(a)(30)(A) of the Social Security Act (... "payments are consistent with economy, efficiency, and quality of care and are sufficient to enlist enough providers") and the related federal regulations at 42 CFR 447.200-205. The State of Delaware reviews the rate setting model every three years to ensure the adequate access to services and appropriate levels of reimbursement are maintained.

The component parts of the rates are cross walked or translated into a total number of support hours needed by each person as determined through the completion of the Inventory for Client and Agency Planning (ICAP) assessment tool. The ICAP assessments are performed face-to-face by an independent clinician for whom the state contracts (Arbitre Consulting, Inc.). The contractor submits the completed assessments via a HIPAA compliant means to the State. The ICAP assessment scores are used to generate a daily rate for the individual receiving services. For individuals receiving "prevocational - daily" or "day habilitation - daily" services, the daily rate is calculated through the use of a matrix which specifies the needed hours of service based on ICAP generated Broad Independence and General Maladaptive scores. These hours of services are converted to a daily rate by multiplying the needed hours of services by a rate per hour. The hourly rate is calculated using a set direct care wage and includes percentage add-ons for Employee Related Expenses (ERE), Program Indirect (PI) Expenses and Contract Administration. For individuals receiving "prevocational - hourly" or "day habilitation - hourly" services, the hourly rate, defined above, is paid for the actual hours of service received, billed in 15 minute increments.

Rates for day programs and prevocational services also have add-ons for Transportation and Facility costs. Rates are calculated by the DDDS Office of Budget, Contracts and Business Services. The rate setting system/methodology is outlined in the Mercer final report and the ICAP Rate Setting Matrix located on the State of Delaware website under Delaware Health and Social Services, Division of Developmental Disabilities Services, Individual Rate Setting.

Provider agencies and/or participants have the right to request a review of a rate if they do not feel the calculated rate is adequate. In a review, the agency/participant submits supporting documentation to the Director of Community Services who makes a recommendation for an exception to the Chief of Administration. The base unit rates, ERE and PI percentages, transportation and facility add-ons and matrix are published and are available for public comment and input. The ICAP rate process and establishment of rates are approved by the Delaware Division of Medicaid and Medical Assistance (DMMA) and the Rate Setting Committee.

Rates for "Supported Employment - Individual" have been calculated using actual cost data as reported by providers of Supported Employment Services. Total Medicaid allowable costs for each provider were tabulated and divided by total direct care staff (job coaches, employment specialists) hours worked. This provided a cost per hour for each provider based on direct care staff hours. The average cost per hour across all agencies was used to compute an hourly rate, which is expressed as a 15 minute billable unit by dividing the hourly rate by four.

Rates for Supported Employment - Small Group are based on the rate for Supported Employment - Individual, which is a one-to-one staff-to-consumer ratio. The payment rate for the addition of each consumer in the group shall be computed by dividing the payment rate for Supported Employment - Individual by the number of participants in the group (up to a maximum of 8) and applying a gross up factor to account for additional incremental costs related to the provision of group supported employment that would not have been captured in the base rate for Supported Employment - Individual. Supported Employment - Small Group will be paid in 15 minute billable units.

The rates for the services of the State of Delaware operated Day Programs are calculated based on the total actual annual costs, including personnel, benefits, supplies, and administration or overhead. The total actual costs are used to calculate a daily rate for this service. The Day Program rate is approved by Delaware's DMMA and Revenue Management Units. This area has been incorporated into an approved work plan and will be revised in accordance with the goals, objectives and timeframes identified in the work plan. The work plan includes the revision of the rate methodology for State Run Day Habilitation, Residential Habilitation, DDDS State Case Management, and Clinical/Behavioral consultative services. Transportation costs are now included in, and have been built into, the Residential Habilitation Services rate. See Work plan Section II.A.1-II.A.11 & III.A.1- III.A.7

Behavioral Consultation Services □ a single statewide rate will be developed for this service as follows. The midpoint of the salary range for the State of Delaware merit classification of Senior Behavior Analyst will be used as the basis of the computation of an hourly wage. A fringe benefit factor is added to the hourly wage based on the

Delaware State Employee fringe benefit package. A factor of 12% is added to the computed hourly wage that includes other employment costs to account for other direct non-salary costs such as training, supervision and travel. A separate factor of 12% is added on top of the computed hourly wage to account for administrative costs necessary to support the direct service. A 15 minute billable unit is computed by dividing the resulting hourly wage by four. The provision of behavioral consultation services and related documentation of the provision of service shall be billable in 15 minute increments. Units of time 1- 8 minutes shall not be billed. Units of time 8-15 minutes shall be billed as one 15 minute unit.

Nursing Consultation Services □ a single statewide rate will be developed for this service as follows. National average hourly wage data is obtained from the Bureau of Labor Statistics, Occupational Employment Statistics survey of the US DOL for the Registered Nurse job classification SOC code 29-1111 (Registered Nurse) in the industry code NAICS 623210 Residential MR Facilities. A fringe benefit factor is added to the hourly wage based on the Delaware State Employee fringe benefit package. A factor of 12% is added to the computed hourly wage that includes other employment costs to account for other direct non-salary costs such as training, supervision and travel. A separate factor of 12% is added on top of the computed hourly wage to account for administrative costs necessary to support the direct service. A 15 minute billable unit is computed by dividing the resulting hourly wage by four. The provision of nursing consultation services and related documentation of the provision of service shall be billable in 15 minute increments. Units of time 1- 8 minutes shall not be billed. Units of time 8-15 minutes shall be billed as one 15 minute unit.

- 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 HCBS waiver services are adjudicated by the State's Medicaid Fiscal Agent, HP, 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 accepted, in which case they pass to the MMIS for adjudication if they meet the minimum criteria, or are rejected back to the provider along with the rejection reason. Providers can submit paper claims on the HCFA 1500 or the UB04 directly to HP. Paper claims are scanned into the MMIS. Providers can use any claims software resulting in a HIPAA standard clean claim. HIPAA compliant claims software is made available to DMAP providers free of charge via download from the DMAP website. Provider billing procedures are described in detail in a series of Provider Manuals on the DMAP website.

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

This area has been incorporated into an approved work plan and will be revised in accordance with the goals, objectives and timeframes identified in the work plan. See Work plan Section II.A.1-II.A.11 & III.A.1- III.A.7

The billing for state-operated day habilitation, residential habilitation, residential transportation, case management services, and state clinical consultative services are entered as the State of Delaware/DDDS being the provider agency (where/when applicable). This area has been incorporated into an approved work plan and will be revised in accordance with the goals, objectives and timeframes identified in the work plan. See Work plan Section II.A.1-II.A.11 & III.A.1- III.A.7

The State of Delaware submits electronic claims in the HIPAA standard 837 transactions (professional) first to a clearinghouse, Business Exchange Services (BES) which screens them against both HIPAA and Delaware proprietary minimum claim criteria. Accepted claims are passed to the MMIS for adjudication if they meet the minimum criteria, or are rejected back to the State along with the rejection reason. The State of Delaware uses HIPAA compliant claims software that is made available to DMAP providers free of charge via download from the DMAP website.

Appendix I: Financial Accountability

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

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

The payment for case management is a workplan item and the waiver will be modified to reflect the change to an administrative function. Transportation payment is a workplan item as well. Clinical Support payment issues will be addressed as a workplan action steps.

(b) The participants' Essential Lifestyle Plan lists and details the approved services prepared at the beginning of services and re-evaluated at a minimum annually or on an as needed basis (when applicable as situations change) thereafter. Once eligible for HCBS waiver services a contract is secured for the individual receiving services and their chosen provider(s). HCBS waiver services are pre-authorized by the state contract manager and entered into the Atlantes Care Management System based on services selected by each participant during the ELP process. The MMIS checks each claim submitted by a provider against the eligibility record to insure the person receiving service was eligible for waiver services on the date of service and the service was authorized and did not exceed programmed service limitations as set by the pre-authorization.

Per the MOU between DMMA and DDDS, DDDS periodically reviews claims data against plans of care to monitor over and under utilization of services. DMMA is responsible for retrospective auditing of paid claims and utilization review of services provided through DDDS.

(c) Before a claim is processed there must be verification the service was provided. This verification varies according to the service; however the verification must be in writing and signed (either written or electronically) by the provider of service. The agencies providing residential, day, prevocational, and supported employment services are required to submit attendance/utilization reports to the DDDS monthly. These attendance reports are signed by a provider employee and verified by a provider supervisory employee as to verify that services were rendered.

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

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

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

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

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

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

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

Case Management Total:						4275571.20
Case Management	Month	940	12.00	379.04	4275571.20	
Day Habilitation Total:						7092600.00
Day Habilitation - Daily	Day	240	250.00	118.21	7092600.00	
Day Habilitation - 15 minutes	Hour	0	0.00	0.01	0.00	
Prevocational Services Total:						9064800.00
Prevocational Services - Daily	Day	480	250.00	75.54	9064800.00	
Prevocational Services - 15 minutes	Hour	0	0.00	0.01	0.00	
Residential Habilitation Total:						66428209.50
Residential Services	Day	745	360.00	238.25	63898650.00	
Shared Living Arrangement	Day	195	365.00	35.54	2529559.50	
Supported Employment - Individual Total:						1693612.50
Supported Employment - Daily	Day	95	250.00	71.31	1693612.50	
Supported Employment - 15 minutes	Hour	0	0.00	0.01	0.00	
Supported Employment - Small Group Total:						0.00
Supported Employment - Small Group		0	0.00	0.01	0.00	
Clinical Consultative Services; Behavioral Consultative Services/Nursing Consultative Services Total:						4984608.00
Behavioral Consultative Services	Quarter Hour	0	0.00	0.01	0.00	
Nursing Consultative Services	Quarter Hour	0	0.00	0.01	0.00	
Clinical Consultative Services; Behavioral Consultative Services/Nursing Consultative Services	Month	685	12.00	606.40	4984608.00	
Transportation - Residential Services Total:						1226476.80
Transportation - Residential Services	Month	535	12.00	191.04	1226476.80	
GRAND TOTAL:						94765878.00
Total Estimated Unduplicated Participants:						940
Factor D (Divide total by number of participants):						100815.00
Average Length of Stay on the Waiver:						350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to

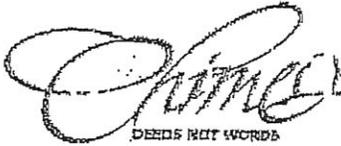
automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						4546651.20
Case Management	Month	980	12.00	386.62	4546651.20	
Day Habilitation Total:						7536250.00
Day Habilitation - Daily	Day	250	250.00	120.58	7536250.00	
Day Habilitation - 15 minutes	Hour	0	0.00	0.01	0.00	
Prevocational Services Total:						9920187.50
Prevocational Services - Daily	Day	515	250.00	77.05	9920187.50	
Prevocational Services - 15 minutes	Hour	0	0.00	0.01	0.00	
Residential Habilitation Total:						70514986.25
Residential Services	Day	775	360.00	243.02	67802580.00	
Shared Living Arrangement	Day	205	365.00	36.25	2712406.25	
Supported Employment - Individual Total:						1818500.00
Supported Employment - Daily	Day	100	250.00	72.74	1818500.00	
Supported Employment - 15 minutes	Hour	0	0.00	0.01	0.00	
Supported Employment - Small Group Total:						0.00
Supported Employment - Small Group		0	0.00	0.01	0.00	
Clinical Consultative Services: Behavioral Consultative Services/Nursing Consultative Services Total:						5344099.20
Behavioral Consultative Services	Quarter Hour	0	0.00	0.01	0.00	
Nursing Consultative Services	Quarter Hour	0	0.00	0.01	0.00	
Clinical Consultative Services: Behavioral Consultative Services/Nursing Consultative Services	Month	720	12.00	618.53	5344099.20	
Transportation - Residential Services Total:						1314135.84
Transportation - Residential Services	Month	562	12.00	194.86	1314135.84	
GRAND TOTAL:						100994809.99
Total Estimated Unduplicated Participants:						980
Factor D (Divide total by number of participants):						103955.93
Average Length of Stay on the Waiver:						350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)



Vocational Monthly Note

Between: 6/1/13 and 6/30/13

SAMPLE

Newark Delaware

Employee #: Employee Name:
Case Manager:

Dear .

has worked on the following contracts between 6/1/13 and 6/30/13

If you have any questions or concerns regarding the below information, please feel free to contact me at any time at 1-800-9CHIMES.

CODE	DESCRIPTION	HOURLY UNITS	GROSS SE PAY
AA0001001	A & A Co Parkway Machine co Contract Production		\$0.00
MH0001001	Material Handling/ Warehouse inside Warehouse - moving product		\$0.00
NON006001	Facility Closed Non Production		\$0.00
NON026001	Absent Non Production		\$0.00
NON023001	Arrived Late or left early Non Production		\$0.00



Vocational Monthly Note

Between: 6/1/13 and 6/30/13

Newark Delaware

Employee #: Employee Name:
Case Manager:

Work Hours

	Hours	Percentage	units
Community Employment	0	0.00%	NA
Supported Employment	0	0.00%	NA
Assessments	0	0.00%	NA
Contract hours		100.00%	1500
Total work Hours			

Wage

	Pay	Percentage
Work center Pay		100.00%
Supported Employment	\$0.00	0.00%
Total Pay		
Avg. Wage		

Behavioral

	Hours	Percentage
Refusal	0	0.00%
Behavioral Interference	0	0.00%
Behavioral interference from others	0	0.00%
Total Behavior Hours Interfering W/pay	0	

Non Work Activities

	Hours	Percentage
Transportation		0.00%
Intergration		0.00%
Absent		48.70%
Late/Early arrival		39.13%
Closed		12.17%
Refusal		0.00%
Breaks/ Trastitions		0.00%
Other Non-Work Hrs		0.00%
Total Non-Work Hrs		0

Percentage of Intergration Activities

Community Emp. Hrs	Supported Emp. Hrs	Asses ments	Transportation	Other Hours	Total Integration hrs
0	0		0	0	0
Total Chimes Hrs	Absent Hr	Late/ Early	Closed	Adjusted Chime Hrs	Total Integration hrs
					0.00%