DELAWARE HEALTH AND SOCIAL SERVICES
Delaware Division of Medicaid & Medical Assistance

Delaware
HCBS Settings Required Reporting
January 1, 2023

As required by CMS, this document describes Delaware's response to the following:

- How the state's oversight systems have been modified to embed the regulatory criteria into ongoing operations;
- How the state assesses providers for initial compliance and conducts ongoing monitoring for continued compliance; and
- A beneficiary's recourse to notify the state of setting non-compliance and how the state will address beneficiary feedback.

As a reminder, Delaware operates four HCBS programs. See chart below for programs and operating entities.

Program	Operating Agency
Diamond State Health Plan (DSHP) Plus (1115)	DMMA
Lifespan (1915c)	DDDS
PROMISE (1115)	DSAMH
Pathways (1915i/1915b)	DDDS

The following applies in general to all Delaware HCBS programs. Where applicable, operations unique to a program/operating agency are specified. Details can be found in the approved Delaware Statewide Transition Plan.

How the state's oversight systems have been modified to embed the regulatory criteria into ongoing operations

- Updated residential settings licensing standards to address HCBS Final Rule requirements
- Updated operating policies and procedures to address HCBS final rule requirements
- Updated managed care organization (MCO) contract to define MCO roles and expectations
- Self-assessment tool for use by providers and MCOs to assess compliance with HCBS settings federal requirements based on the CMS exploratory questions
- Tool for use by state entities and MCOs to assess provider compliance with HCBS settings requirements, based on the CMS exploratory questions
- Trainings for providers, case managers, and MCOs on HCBS Final Rule requirements, roles, and expectations
- Using findings from the NCI-AD survey to assess provider compliance with the HCBS settings requirements from the beneficiary's perspective

- Assessment of MCOs' compliance with HCBS Final Rule incorporated into annual external quality review

How the state assesses providers for initial compliance and conducts ongoing monitoring for continued compliance

Initial Compliance

HCBS providers new to the system must be compliant with the HCBS settings requirements, and, as appropriate, must meet all applicable licensure requirements prior to providing services. An on-site review will be conducted to assess compliance using a tool based on the CMS exploratory questions.

For DSHP Plus, providers will first complete and submit a provider self-assessment. Similar to the tool used for on-site reviews, the provider self-assessment tool is based on the CMS exploratory questions. After review of the provider self-assessment, an on-site review will be conducted. The findings from the provider self-assessment will serve as the basis for the on-site review.

Identified issues are discussed with the provider. If an issue cannot be resolved timely (within four weeks of the date of notification), the provider will be placed on a corrective action plan (CAP). CAPs are developed for a specified timeframe and will include defined tasks to remediate identified issues. The operating agency will closely monitor implementation of the CAP. For DSHP, the MCO will monitor implementation of the CAP. If a provider fails to complete the CAP, the MCO will not contract with the provider.

Providers unable to resolve identified issues within prescribed timeframes will be found non-compliant and be removed from the program as a viable HCBS provider.

Timeframes for the process will vary depending on the operating agency.

Ongoing Monitoring

Case managers will monitor the beneficiary's experience and provider compliance with HCBS settings requirements during regular check in meetings.

An annual on-site review is conducted for all residential or day providers.

For DSHP Plus, providers will be assessed as part of the re-credentialing process. Providers will first complete a self-assessment tool, based on the CMS exploratory questions. If any issues are identified from review of the provider self-assessment, MCOs will conduct an on-site review.

Identified issues are discussed with the provider. If the issue cannot be addressed timely (within four weeks of the date of notification), the provider will be placed on a CAP. CAPs are developed for a specified timeframe and will include defined tasks to remediate identified issues. The operating agency will closely monitor implementation of the CAP. For DSHP Plus, the MCO will monitor implementation of the CAP.

Providers unable to resolve identified issues within prescribed timeframes will be found non-compliant and removed from the program as a viable HCBS provider.

Timeframes for the process will vary depending on the operating agency.

A beneficiary's recourse to notify the state of setting non-compliance, and how the state will address beneficiary feedback

As the first line of defense in ensuring health and welfare in HCBS programs, case managers will assess provider compliance as part of regular check-in meetings. The assessment will occur through a combination of questions and observation. Beneficiaries (their families, guardians, and/or caregivers) can also contact case managers at any point to note provider issues or concerns.

Beneficiaries (their families, guardians, and/or caregivers) can also report issues via the program's complaint reporting process. Issues will be triaged and will receive immediate attention.

Identified issues are shared with the appropriate operating agency. In turn, the applicable operating agency will follow up with the provider, noting the identified issue and location. Beneficiaries lodging the complaint will remain anonymous. If the issue cannot be addressed timely (within four weeks of the date of notification), the provider will be placed on a CAP. Issues unable to be resolved within a reasonable timeframe may result in loss of certification as an HCBS provider and require relocation of all beneficiaries.

Case managers will closely monitor beneficiaries during the CAP process and inform beneficiaries of the outcome. If needed, case managers will work with beneficiaries to find an alternative HCBS provider of their choosing and to ensure continuity of services.