STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: DELAWARE

TELEMEDICINE

The Delaware Medical Assistance Program (DMAP) covers medically necessary health services furnished to eligible DMAP members as specified in the Medicaid State Plan. To facilitate the ability of recipients to receive medically necessary services, DMAP allows for the use of a telemedicine delivery system for providers enrolled under Delaware Medicaid.

Telemedicine services under DMAP are subject to the specifications, conditions, and limitations set by the State. Telemedicine is the practice of health care delivery by a practitioner who is located at a site, known as the distant site, other than the site where the patient is located, known as the originating site, for the purposes of consultation, evaluation, diagnosis, or recommendation of treatment. An approved originating site may include the DMAP member’s place of residence, day program, or alternate location in which the member is physically present and telemedicine can be effectively utilized.

Providers rendering telemedicine must be able to use interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time, interactive communication between the recipient and the practitioner to provide and support care when distance separates participants who are in different geographical locations.

The provision of services through telemedicine must include accommodations, including interpreter and audio-visual modification, where required under the Americans with Disabilities Act (ADA), to ensure effective communication.

Telephone conversations, chart reviews, electronic mail messages, facsimile transmissions or internet services for online medical evaluations are not considered telemedicine.

All equipment required to provide telemedicine services is the responsibility of the providers.
PROVIDER QUALIFICATIONS

In order to provide telemedicine under DMAP, providers at both the originating and distant site must be enrolled with DMAP or have contractual agreements with the managed care organizations (MCOs) and must meet all requirements for their discipline as specified in the Medicaid State Plan.

For services delivered through telemedicine technology from DMAP or MCOs to be covered, healthcare practitioners must:

- Act within their scope of practice;
- Be licensed (in Delaware, or the State in which the provider is located if exempted under Delaware State law to provide telemedicine services without a Delaware license) for the service for which they bill DMAP;
- Be enrolled with DMAP/MCOs;
- Be located within the continental United States.

COVERED SERVICES

DMAP covers medically necessary telemedicine services and procedures covered under the Title XIX State Plan. Qualifying provider services include any covered State Plan service that would typically be provided to an eligible individual in a face-to-face setting by an enrolled provider. Telemedicine is not limited based on the diagnosed medical condition of the eligible recipient. All telemedicine services must be furnished within the limits of provider program policies and within the scope and practice of the provider’s professional standards as described and outlined in DMAP Provider Manuals which can be found at: http://www.dmap.state.de.us/downloads/manuals.html

NON-COVERED SERVICES

If a service is not covered in a face-to-face setting, it is not covered if provided through telemedicine. A service provided through telemedicine is subject to the same program restrictions, limitations and coverage exist for the service when not provided through telemedicine.
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AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases, Provided: ☒ No limitations ☐ With limitations*

2. a. Outpatient hospital services. Provided: ☒ No limitations ☐ With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic. Provided: ☒ No limitations ☐ With limitations*

Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4). Provided: ☒ No limitations ☐ With limitations*

d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age. Provided: ☒ No limitations ☐ With limitations*

3. Other laboratory and x-ray services. Provided: ☒ No limitations ☐ With limitations*

*Description provided on attachment.
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AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY - CONTINUED

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
Provided: ☒ No limitations ☐ With limitations*

4. b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4. c. Family planning services and supplies for individuals of child-bearing age.
Provided: ☐ No limitations ☒ With limitations*

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.
Provided: ☐ No limitations ☒ With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905 (a) (5) (B) of the Act).
Provided: ☐ No limitations ☒ With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.
Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY - CONTINUED

LIMITATIONS:

4. c. Family Planning: Delaware Medicaid does not pay for fertility related services or items.

5.a. Physicians Services: The Delaware Medicaid program does not cover any procedure which is considered experimental by the Medicare program with the exception of transplants as defined on ATTACHMENT 3.1-A, Page 1 Addendum.

5.b. Medical and surgical services furnished by a dentist: These services are limited to those normally covered under this State Plan and which may be provided by a dentist under the rules governing Dental Practice in the State of Delaware.

6. a. Podiatrists' services are limited to surgical procedures and laboratory tests. Medicaid will pay for routine foot care only for people who are diagnosed as having circulatory or vascular disorders or diabetes.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: DELAWARE

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY - CONTINUED

4. d. 1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

- (i) By or under supervision of a physician;
- (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; *or

- (iii) Any other health care professional legally authorized to provide tobacco cessation services under State law and who is specifically designated by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.)

*Describe if there are any limits on who can provide these counseling services

2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided: ☒ No limitations ☐ With limitations*

*Any benefit package that consists of less than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period (eight (8) per year) should be explained below.

Please describe any limitations:
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AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY - CONTINUED

LIMITATIONS:

4.b.

Delaware assures that all medical necessity services available under Title XIX necessary to correct, ameliorate defects and physical and mental illnesses and conditions discovered by the screening services are provided to children as required under section 1905(r) of the Act and codified at 42 CFR 440.40 (b), regardless of whether they are covered in the Delaware State Plan. Limitations in the amount, duration, or scope of services articulated in the State Plan shall not apply to children.

Services not covered by Delaware and therefore not otherwise described elsewhere in the Delaware State Plan, provided in the State Plan with significant limitations not applicable to children or provided in settings or under non-traditional reimbursement arrangements designed to meet the unique needs of children include:

1) Prescribed Pediatric Extended Care (PPEC) facilities that are licensed as such by the State's Office of Health Facilities, Licensing and Certification and that are provided as an alternative to more expensive institutionalization or as an alternative to community/home care for children who are determined to be in medical need of the service. These services include nursing services speech therapy, physical therapy and occupational therapy provided in an outpatient setting, up to twelve hours per day, five days a week.

PPEC services must be prior authorized using policy established by the Delaware Medicaid program.
LIMITATIONS:

4.b. (continued)

2) School-based Health Services - Medicaid covers the following health and mental health services provided or purchased by the Delaware Department of Education (DOE) or Local Education Agency (LEA) when they are medically necessary and furnished by providers meeting specified criteria:

(a) EPSDT screens, including vision, dental, immunization, orthopedic, mental health and developmental screening (per 42 CFR 440.40(b))

(b) Nursing Services, including provision of one-on-one individualized Health Education (per 42 CFR 440.60 and 440.170)

(c) Physical Therapy, Occupational Therapy, Speech Therapy, Language and Hearing Services (per 42 CFR 440.110)

(d) Rehabilitative behavioral health services designed to correct or ameliorate a mental health or developmental disability and restore a recipient to his or her best possible level of functioning as determined via an EPSDT screen and documented in an Individualized Education Plan (IEP)/Individualized Family Service Plan (IFSP) (per 42 CFR 440.130), including:
   • Psychological and developmental assessment
   • Counseling and therapy

(e) Specialized transportation of children (as defined in Title 14 Del.C.§202) between home and school on days when the transportation is necessary to receive a Medicaid-covered service. Both the need for the Medicaid-covered service and the need for transportation must be documented in the child's IEP (per 42 CFR 440.170).

With the exception of EPSDT screens, all services covered under this section are diagnostic or active treatments designed to reasonably improve the student's physical or mental condition and are provided to the student whose condition or functioning can be expected to reasonably improve with interventions.
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LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.b. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Continued

2) School-based Services Continued

With the exception of the EPSDT screening services, all services covered under this section shall be medically necessary and shall be prescribed in a written treatment plan signed by a licensed practitioner within the scope of practice as defined under state law or regulations and documented in the student’s IEP/IFSP. These services are delivered by school providers, but are also available in the community from other providers.

Services must be provided by licensed qualified providers who meet the requirements of the regulations cited above in this section and other applicable state law and regulations as per 42 CFR 440.60. Unlicensed professionals may operate under the direction of a licensed practitioner who acts as supervisor and is responsible for the work, plans the work and methods, who regularly reviews the work performed and is accountable for the results. Supervision must adhere to the requirements of the practitioner’s applicable licensing board. The licensed practitioner must co-sign documentation for all services provided by practitioners under his or her direction.

Providers must maintain all records necessary to fully document the nature, quality, amount and medical necessity of services furnished to Medicaid recipients.

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STATE/TERRITORY: DELAWARE

LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.b. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Continued

3) Medical Equipment and Supplies per 42 CFR 440.70

4) Orthotics and Prosthetics

5) Chiropractic Services

6) Any other medical or remedial care provided by licensed medical providers as authorized under 42 CFR 440.60. Unlicensed professionals may operate under the direction of a licensed practitioner who acts as supervisor and is responsible for the work, plans the work and methods, who regularly reviews the work performed and is accountable for the results. Supervision must adhere to the requirements of the practitioner’s applicable licensing board. The licensed practitioner must co-sign documentation for all services provided by practitioners under his or her direction.

7) Any other services as required by §6403 of OBRA ‘89 as it amended §1902(a)(43), §1905(a)(4)(B) and added a new §1905(r) to the Act.

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STATE/TERRITORY: DELAWARE

LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.b. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Continued

7. Rehabilitative Services - 42 CFR 440.130(d)
   The following explanations apply to all rehabilitative services, which include the following services:

   1. Community Psychiatric Support and Treatment
   2. Psychosocial Rehabilitation
   3. Crisis Intervention
   4. Family Peer Support Services
   5. Rehabilitative Residential Supports

These rehabilitative services must be recommended by a licensed behavioral health practitioner (Licensed Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor of Mental Health, or Licensed Marriage and Family Therapist), physician, nurse practitioner, or physician assistant who is acting within the scope of his/her professional license and applicable state law and furnished under the direction of one of the above listed licensed practitioners, to promote the maximum reduction of symptoms and restoration of an individual to his/her best age-appropriate functional level. These rehabilitative services are provided according to an individualized treatment plan, which is subject to prior approval. The activities included in the service must be intended to achieve identified treatment plan goals or objectives. The treatment plan should be developed in a person-centered manner with the active participation of the individual, family and providers and be based on the individual’s condition and the standards of practice for the provision of these specific rehabilitative services. At a minimum, annual reevaluations of the treatment plan will occur. The reevaluation of the treatment plan should involve the individual, family and providers and include a reevaluation of plan to determine whether services have contributed to meeting the stated goals. A new treatment plan should be developed if there is no measurable reduction of disability or restoration of functional level. The new plan should identify a different rehabilitative strategy with revised goals and services.
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LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.b. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Continued

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

EPSDT Rehabilitation Attestations: The State assures that all rehabilitative services are provided to, or directed exclusively toward the treatment of, the Medicaid eligible child in accordance with section 1902(a)(10)(A)(i) of the Act. Medically necessary services will be furnished to those under age 21 without limitation in accordance with 1905(r) of the Social Security Act. The State also assures that rehabilitative services do not include, and FFP is not available for, any of the following in accordance with section 1905(a)(13) of the Act:

A. Educational, vocational and job training services;
B. Room and board;
C. Habilitation services;
D. Services to inmates in public institutions as defined in 42 CFR §435.1010;
E. Services to individuals residing in institutions for mental diseases as described in 42 CFR §435.1010;
F. Recreational and social activities; and
G. Services that must be covered elsewhere in the Delaware Medicaid State Plan.

Provider Agency Qualifications: Any unlicensed practitioner providing behavioral health services must operate within an agency licensed, certified or designated by DHSS or its designee qualified to provide the supervision required of an unlicensed practitioner for that service. Any entity providing Substance Use Disorder (SUD) treatment services must be certified by Delaware Health and Social Service (DHSS) or its designee, in addition to any required scope of practice license required for the facility or agency to practice in the State of Delaware. The following Evidence-Based Practices (EBPs) require prior approval and fidelity reviews on an ongoing basis as determined necessary by DHSS or its designee: Multi-Systemic Therapy (MST), Functional Family Therapy (FFT), Dialectical Behavior Therapy (DBT), Parent-Child Interaction Therapy (PCIT), and Family –Based Mental Health Services. Additional EBP techniques not requiring ongoing fidelity reviews, such as Trauma-Focused-Cognitive Behavior Therapy and Motivational Interviewing, may be integrated into rehabilitation services by providers without prior approval. The State will ensure, under 1905(r)(5) of the Social Security Act, that medically necessary and individually responsive EPSDT services reflecting the latest medical practices for children will be provided in a timely manner even if the EBP is not otherwise listed in the State Plan.
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LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
PROVIDED TO THE CATEGORICALLY NEEDY

4.b. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Continued

7. Rehabilitative Services - 42 CFR 440.130(d) Continued
Rehabilitative services are defined as follows:

1. Community Psychiatric Support and Treatment (CPST) are goal directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the individual’s individualized treatment plan. Solution focused interventions, emotional and behavioral management, and problem behavior analysis includes the implementation of interventions using evidence-based techniques, drawn from cognitive-behavioral therapy and/or other psychotherapeutic interventions that ameliorate targeted symptoms and/or recover the person’s capacity to cope with or prevent symptom manifestation. CPST is a face-to-face intervention with the individual, family or other collaterals with all treatment and activities related directly to goals on the Medicaid beneficiary’s rehabilitation treatment plan. CPST contacts may occur in community or residential locations where the person lives, works, attends school, and/or socializes. This service may include the following components:

   A. Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual’s mental illness, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the individual’s life.

   B. Individual supportive counseling including solution focused interventions, emotional and behavioral management, and problem behavior analysis drawn from cognitive-behavioral therapy and/or other evidence-based psychotherapeutic interventions that ameliorate targeted symptoms and/or recover the person’s capacity to cope with or prevent symptom manifestation. The goal is to assist the individual to acquire skills to minimize symptoms that interfere with the individual’s ability to develop and maintain social, interpersonal, self-care, and independent living skills needed to improve and to restore stability and daily functioning within the individuals natural community settings.

   C. Participation in and utilization of strengths based planning and treatments which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their mental illness.

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LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.b. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Continued

7. Rehabilitative Services - 42 CFR 440.130(d) Continued
   1. Community Psychiatric Support and Treatment (CPST) Continued
      D. Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk the individual remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or as appropriate, seeking other supports to restore stability and functioning.
      E. Assisting the individual to restore and enhance rehabilitative daily living skills including:
         1. Coping with and managing psychiatric symptoms, trauma and substance use disorders;
         2. Promoting wellness and recovery support;
         3. Learning to independently navigate the service systems;
         4. Setting personal goals; and
         5. Enhancing community living skills specific to managing their own home including managing their money, medications, and using community resources and other self-care requirements;
         6. Enhance resiliency/recovery-oriented attitudes such as hope, confidence and self-efficacy;
         7. Improving Self-Advocacy, Self-Efficacy & Empowerment skill building to -
         8. Develop, link to and facilitate the use of formal and informal resources, including connection to peer support groups in the community;
         9. Serve as an advocate, mentor or facilitator for resolution of issues; and
         10. Assist in navigating the service system.

The following are applicable to all components of the service CPST listed above A-E.
   i. Provider qualifications: Must have a Bachelor of Arts/Bachelor of Science (BA/BS), Master of Arts/Master of Science (MA/MS) or doctorate degree in social work, counseling, psychology or a related human services field to provide all aspects of CPST including counseling. Other aspects of CPST except for counseling may otherwise be performed by an individual with BA/BS degree in social work, counseling, psychology or a related human services field or four years of equivalent education and/or experience working in the human services field. Certification in the State of Delaware to provide the service includes criminal, professional background checks, and completion of a State-approved standardized basic training program including: Mandatory Reporting of Child Abuse and Neglect; Risk Management and Safety Planning; Trauma Informed Care; Family Engagement; and Basic Child Development.
4.b. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Continued

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

1. Community Psychiatric Support and Treatment (CPST) Continued

   ii. Service Utilization: Under EPSDT there are no limitations on services to children. Service Utilization decisions are applied to CPST in its totality, not by each component, based on the medical necessity for that individual child.

   The CPST provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a physician, nurse practitioner or licensed behavioral health practitioner (LBHP) with experience regarding this specialized mental health service.

2. Psychosocial Rehabilitation (PSR) Services are designed to assist the individual compensate for or eliminate functional deficits and interpersonal and/or behavioral health barriers associated with his or her mental illness. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual’s individualized treatment plan. The intent of psychosocial rehabilitation is to restore the fullest possible integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention. These services provide the training and support necessary to ensure engagement and active participation of the child in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. The structured, scheduled activities provided by this service emphasize the opportunity for the child to expand the skills and strategies necessary to move forward in meeting his or her personal life goals and to support his or her transition into adulthood. PSR is a face-to-face intervention with the individual present with all activities directly related to goals on the Medicaid individual’s rehabilitation treatment plan. Services may be provided individually or in a group setting. PSR contacts may occur in community or residential locations where the individual lives, works, attends school, and/or socializes.
4.b. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Continued

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

2. Psychosocial Rehabilitation (PSR) Services

PSR components include:

A. Restoration, rehabilitation and support with the development of social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, develop coping strategies, and promote effective functioning in the individual’s social environment including home, work and school.

B. Restoration, rehabilitation and support with the development of skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with the individual’s daily functioning. Supporting the individual with enhancement and implementation of rehabilitative daily living skills and daily routines critical to remaining in the community.

C. Assistance with the implementation of rehabilitation interventions and learned skills as outlined in the treatment plan so the individual can remain in a natural community location.

D. Assistance with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.

The following are applicable to all components of the service PSR listed above A-D.

i. Provider Qualifications: Must be at least 21 years old, and have a high school diploma or equivalent. Certification in the State of Delaware to provide the service includes criminal, professional background checks, and completion of a State-approved standardized basic training including: Mandatory Reporting of Child Abuse and Neglect; Risk Management and Safety Planning; Trauma Informed Care; Family Engagement; and Basic Child Development.
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LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.b. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Continued

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

2. Psychosocial Rehabilitation (PSR) Services Continued

   ii. Service Utilization: Under EPSDT there are no limitations on services to children. Service Utilization decisions are applied to PSR in its totality, not by each component, based on the medical necessity for that individual child. Prior authorization of the treatment plan is required for all PSR services. A child may have additional services authorized when medically necessary through prior authorization.

   Supervision: The PSR provider must receive regularly scheduled clinical supervision from a professional meeting the qualifications of a physician, nurse practitioner or licensed behavioral health practitioner (LBHP) with experience regarding this specialized mental health service.

3. Crisis Intervention (CI) services are provided to an individual who is experiencing a psychiatric crisis, designed to interrupt and/or ameliorate a crisis experience including a preliminary assessment, immediate crisis resolution and de-escalation, and referral and linkage to appropriate community services to avoid more restrictive levels of treatment. The goals of Crisis Intervention are symptom reduction, stabilization, and restoration to a previous level of functioning. All activities must occur within the context of a potential, or actual, or perceived psychiatric crisis.

   Crisis Intervention is a face-to-face intervention and can occur in a variety of locations, where the individual lives, works, attends school, and/or socializes.

   Crisis Intervention activities include:

   A. A preliminary assessment of risk, mental status, and medical stability and the need for further evaluation or other behavioral health services. Includes contact with the client, family members or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment and/or referral to other alternative mental health services at an appropriate level.

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LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.b. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Continued

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

3. Crisis Intervention Services, Activities Continued

   B. Short-term crisis interventions including crisis resolution and de-briefing with the identified Medicaid eligible individual.

   C. Follow-up with the individual, and as necessary, with the individual’s caretaker and/or family members.

   D. Consultation with a physician or with other qualified providers including nurse practitioners and licensed behavioral health practitioner (LBHP) as defined in 3.1-A Page 3 to assist with the individual’s specific crisis.

Provider Qualifications: Unlicensed staff must be at least 21 years old and have an Associate of Arts/Associate of Science (AA/AS) degree in social work, counseling, psychology or a related human services field or two years of equivalent education and/or experience working in the human services field. Certification in the State of Delaware to provide the service, which includes criminal and professional background checks, and completion of basic training in topics including recovery resiliency, cultural competency, safety, care coordination, risk management and suicide prevention, post-intervention, person-centered care, and de-escalation techniques.

Service Utilization: All individuals who self-identify as experiencing a seriously acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved to effectively resolve it are eligible. An individual in crisis may be represented by a family member or other collateral contact that has knowledge of the individual’s capabilities and functioning. Individuals in crisis who require this service may be using substances during the crisis. Substance use should be recognized and addressed in an integrated fashion as it may add to the risk increasing the need for engagement in care.
4.b. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Continued

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

3. Crisis Intervention Services Continued

The crisis plan developed by the unlicensed professional from the assessment and all services delivered during a crisis must be provided under the supervision of a physician, nurse practitioner, or licensed behavioral health practitioner (LBHP) with experience regarding this specialized mental health service and as such must be available at all times to provide back up, support, and/or consultation. Crisis services may require a medical clearance if substance use is suspected to ensure that the individual is not a danger to himself or others. A medical clearance ensures in an emergent situation that there is not a risk to the individual by means of overdose, withdrawal, etc. where a hospital or another service would better meet the needs of the child.

Crisis Intervention – Emergent is authorized up to (six) 6 hours per episode. However, this may be exceeded based on medical necessity per EPSDT. Ongoing is authorized up to seventy-two (72) hours per episode. An episode is defined as the initial face to face contact with the individual until the current crisis is resolved, not to exceed seventy-two (72) hours without prior authorization by DHSS or its designee. The individual’s chart must reflect resolution of the crisis, which marks the end of the current episode. If the individual has another crisis within seven (7) calendar days of a previous episode, it shall be considered part of the previous episode and not a new episode. Initial authorizations can be exceeded in all instances where it is medically necessary to do so through prior authorization.

4. Family Peer Support Services (FPSS) are an array of formal and informal services and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance use and/or behavioral challenges in their home, school, placement, and/or community. FPSS provide a structured, strength-based relationship between a Family Peer Advocate (FPA) and the parent/family member/caregiver for the benefit of the child.

Family is defined as the primary caregiving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive or self-created unit of people residing together or those with a significant relationship outside the home, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/care-giving for the child(ren).
4.b. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Continued

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

4. Family Peer Support Services Continued

Activities included must be intended to achieve the identified goals or objectives as set forth in the individual’s treatment plan. FPSS is a face-to-face intervention, recommended by a physician, nurse practitioner or licensed behavioral health practitioner (LBHP), operating within the scope of his or her practice with the child, family/caregiver or other collateral supports.

FPSS can be provided through individual and group face-to-face contact and can occur in a variety of settings including community locations where the individual lives, works, attends school, engages in services and/or socializes. Components of FPSS include:

A. Outreach and Information: Empower families to make informed decisions regarding the nature of medical supports and services for themselves and their child.

B. Engagement, Bridging and Transition Support: Provide a bridge between families and Medicaid service providers, support a productive and respectful partnership by assisting the families to express their strengths, needs and goals.

C. Self-Advocacy, Self-Efficacy and Empowerment: Coach and model shared decision-making and skills that support collaboration including educating families about the diagnosis of the child and resources available to empower the family to fully participate and better engage and self-advocate in treatment and service delivery to the eligible child.

D. Parent/guardian/caregiver Psychoeducation: Support the efforts of families in caring for and strengthening their child(ren)’s behavioral health needs directly related to maintaining or improving the child’s diagnosed medical condition.

E. Community Connections and Natural Supports: Enhance the quality of life by supporting the integration of families into their own communities through skill redevelopement with medical supports and services.
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LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.b. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Continued

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

4. Family Peer Support Services Continued

Provider Qualifications: A Family Peer Advocate is an individual who has self-identified as a beneficiary or survivor of mental health and/or substance use disorder (SUD) services, is at least 21 years of age, and meets the qualifications set by the state including specialized peer specialist training, certification and registration. The Family Peer Advocate must have training in the general training requirements required by DHSS or its designee. The training provided/contracted by DHSS or its designee shall be focused on the principles and concepts of peer support and how it differs from clinical support.

The training will also provide practical tools for promoting wellness and recovery, academic information on recovery and resiliency, knowledge about beneficiary rights and advocacy, as well as approaches to care that incorporate creativity. A Family Peer Advocate must have at minimum a high school education or General Educational Development (GED) (preferably with some college background). Each crisis team that includes a Family Peer Advocate staff is supervised by a licensed practitioner of the healing arts who is acting within the scope of his/her professional license and applicable state law.

A Family Peer Advocate is certified by DHSS or its designee. Family Peer Advocates must be trained and certified in the State of Delaware to provide services. The certification includes criminal, abuse/neglect registry and professional background checks, and completion of a State-approved standardized basic training.

Family Peer Advocate may be utilized under clinical supervision for the activities of crisis resolution and debriefing with the identified Medicaid child’s family/caregiver. A candidate with provisional credentials may provide this service while completing certification.
LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.b. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Continued

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

4. Family Peer Support Services Continued

    Supervisor Qualifications: The Family Peer Advocate must receive regularly scheduled supervision from a competent mental health professional meeting the qualifications of either:

    A. A Licensed Behavioral Health Practitioner (LBHP), or

    B. A FPSS supervisor who is an individual working as a Family Peer Advocate for a minimum of five (5) years, in which two (2) years should have been as a credentialed Family Peer Advocate or its equivalent including specialized training and/or experience as a supervisor or alternate credentialing such as reciprocity in another jurisdiction.

Agency Qualifications:

    A. The agency may have an administrative supervisor separate from the clinical supervisor.

    B. The competent mental health professional providing consultation, guidance, mentoring, and on-going training need not be employed by the same agency. Supervision of these activities may be delivered in person or by distance communication methods.
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4.b. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Continued

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

5. Rehabilitative Residential Treatment (RRT) provides community-based rehabilitative residential supports in a setting of no greater than sixteen (16) beds under the supervision and oversight of a licensed behavioral health practitioner (LBHP) (including Psychiatrists, Physicians, Advanced Registered Nurse Practitioners, Psychologists, Licensed Clinical Social Workers, Licensed Professional Counselors of Mental Health, and Licensed Marriage and Family Therapists). The treatment should be targeted to support the restoration of adaptive and functional behaviors that will enable the child to return to and remain successfully in his/her home and community, and to regularly attend and participate in work, school or training. RRTs deliver rehabilitative supports through an array of clinical and related activities including psychiatric supports, integration with community resources and skill-building. RRT treatment must target reducing the severity of the behavioral health issue that was identified as the reason for admission. Most often, targeted behaviors will relate directly to the child ability to function successfully in the home and school environment (e.g., compliance with reasonable behavioral expectations; safe behavior and appropriate responses to social cues and conflicts).

Rehabilitative Residential Treatment must:

A. Focus on reducing the behavior and symptoms of the psychiatric and/or behavioral disorder that necessitated the removal of the child from his/her usual living situation.

B. Decrease problem behavior and increase developmentally-appropriate, normative and pro-social behavior in children who are in need of out-of-home placement.

C. Transition child from RRT to home or community based living with outpatient treatment (e.g., individual and family therapy) including generalizing skills learned in the RRT setting.
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4.b. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Continued

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

5. Rehabilitative Residential Treatment Continued

RRT is organized and staffed to provide both general and specialized residential (e.g., non-institutional, non-hospital) interdisciplinary services twenty-four (24) hours a day, seven (7) days a week for individuals with behavioral health disabilities or co-occurring disabilities. RRT services are organized to provide environments in which the individuals reside and receive services from personnel who are trained in the delivery of services for individuals with behavioral health disorders or related problems. RRT may be provided in freestanding, nonhospital-based facilities. RRTs may include nonhospital addiction treatment centers or other residential non-institutional settings.

The State Medicaid agency or its designee must have determined that less intensive levels of rehabilitative treatment are unsafe, unsuccessful or unavailable. The child must require treatment that would not be able to be provided at a less restrictive level of care than is being provided on a twenty-four (24)-hour basis with direct supervision/oversight by professional behavioral health staff. The setting must be ideally situated to allow ongoing participation of the child’s family with the exception of specialty facilities that are not available locally. The child may attend a school in the community (e.g., a school integrated with children not from the group home and not on the grounds of the group home). Education services may be provided on site for children that cannot attend their community school but are not Medicaid reimbursable.

Service Utilization: Under EPSDT there are no limitations on services to children. Service Utilization decisions are applied to RRT in its totality, not by each component, based on the medical necessity for that individual child.
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4.b. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Continued

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

5. Rehabilitative Residential Treatment Continued

The following components are included under the Rehabilitation Authority and in the RRT service:

A. Individual and Group Interventions to:

1. Ensure restoration of skills through interventions outlined on the child's treatment plan including rehabilitative supports through an array of clinical and related activities including psychiatric supports, integration with community resources and skill-building.

2. Enhance compliance with reasonable behavioral expectations; safe behavior and appropriate responses to social cues and conflicts.

3. Interventions drawn from cognitive-behavioral therapy and/or other evidence-based psychotherapeutic interventions that ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom manifestation and focus on reducing the behavior and symptoms of the psychiatric and/or behavioral disorder that necessitated the removal of the child from his/her usual living situation.

4. Structured interventions to decrease problem behavior and increase developmentally-appropriate, normative and pro-social behavior in children who are in need of out-of-home placement.
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4.b. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Continued

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

5. Rehabilitative Residential Treatment Continued

A. Individual and Group Interventions Continued

Practitioner qualifications: Direct care staff must be at least 21 years old, and have a high school diploma or equivalent, certification in the State of Delaware or the state in which the facility is located to provide the service, which includes criminal, professional background checks, and completion of a State-approved standardized basic training including: Mandatory Reporting of Child Abuse and Neglect; Risk Management and Safety Planning; Trauma Informed Care; Family Engagement; and Basic Child Development.

Supervisor qualification: RRT staff must be supervised by a licensed behavioral health practitioner (LBHP). A licensed behavioral health practitioner (LBHP), or other staff as required by the facility's accrediting body, must provide twenty-four (24) hour, on-call coverage seven (7) days a week. The LBHP must see the client at least once, prescribe the type of care provided, and, if the services are not time-limited by the prescription, review the need for continued care in accordance with the requirements of their accrediting body.

B. Medication Management – The RRT is required to utilize psychotropic medications with specific target symptoms identification, with medical monitoring and twenty-four (24) hour medical availability, when appropriate and relevant; however, the coverage for those medications is under the Medicaid pharmacy authority in the State Plan.

Practitioner qualifications: Medication Management must be performed by an individual with credentials permitting medication management under State law including an RN or an LPN. The credentialed professional must be at least 21 years old be licensed in the State of Delaware or the state in which the facility is located to provide the service, have passed criminal, professional background checks, and completion of a State-approved standardized training including: Medication self-administration, Mandatory Reporting of Child Abuse and Neglect; Risk Management and Safety Planning; Trauma Informed Care; Family Engagement; and Basic Child Development.
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4.b. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Continued

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

5. Rehabilitative Residential Treatment Continued

C. Care Coordination – The RRT staff must transition the child from RRT to home or community based living with outpatient treatment (e.g., individual and family therapy) including generalizing skills learned in the RRT setting. The child may attend a school in the community (e.g., a school integrated with children not from the group home and not on the grounds of the group home). If the child attends school in the community, the RRT staff must coordinate care at school and in the RRT.

Practitioner qualifications: Direct care staff must be at least 21 years old, and have a high school diploma or equivalent, certification in the State of Delaware or the state in which the facility is located to provide the service, which includes criminal, professional background checks, and completion of a State-approved standardized basic training including: Mandatory Reporting of Child Abuse and Neglect; Risk Management and Safety Planning; Trauma Informed Care; Family Engagement; and Basic Child Development.

Supervisor qualifications: RRT staff must be supervised by a licensed behavioral health practitioner (LBHP). A licensed behavioral health practitioner (LBHP), or other staff as required by the facility’s accrediting body, must provide twenty-four (24) hour, on-call coverage seven (7) days a week. The LBHP must see the client at least once, prescribe the type of care provided, and, if the services are not time-limited by the prescription, review the need for continued care in accordance with the requirements of their accrediting body.
4.b. **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Continued**

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

5. Rehabilitative Residential Treatment Continued

RRTs provide twenty-four (24) hours/day, seven (7) days/week structured and supportive living environment. Integration with community resources is provided to plan and arrange access to a range of educational and therapeutic services. An assessment is required to document and to track progress and revise the treatment plan to address any lack of progress and to monitor for current medical problems and concomitant substance use issues. The individualized, strengths-based services and supports:

A. Are identified in partnership with the child and the family and support system, to the extent possible, and if developmentally appropriate;

B. Are based on both clinical and functional assessments;

C. Are clinically monitored and coordinated, with twenty-four (24) hour availability;

D. Are implemented with oversight from a licensed mental health professional;

E. Assist with the development of skills for daily functioning and support success in community settings, including home and school.

The RRT is required to coordinate with the child’s community resources including Medicaid community-based behavioral health treatment when possible, with the goal of transitioning the child out of the RRT as soon as possible and appropriate. Discharge planning begins upon admission with concrete plans for the child to transition back into the community beginning within the first fifteen (15) days of admission with clear action steps and target dates outlined in the treatment plan. The treatment plan must include behaviorally-measurable discharge goals.
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LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
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4.b. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Continued

7. Rehabilitative Services - 42 CFR 440.130(d) Continued

5. Rehabilitative Residential Treatment Continued

Provider Agency qualifications: A RRT must be accredited and licensed as residential treatment facility by DHSS or its designee and may not exceed sixteen (16) beds. RRT staff must be supervised by a licensed behavioral health practitioner (LBHP). Licensed psychologists and licensed behavioral health practitioners are covered separately under the approved State Plan for Other Licensed Practitioners. The RRT must have at least one (1) personnel member immediately available at all times who is trained in: First aid; Cardiopulmonary resuscitation (CPR); and the use of emergency equipment. RRT facilities may specialize and provide care for sexually abusive behaviors, substance abuse, or dually diagnosed individuals (e.g., either mental health/developmentally disabled or mental health/substance use disorder). If a RRT provides care to any of these categories of child, the RRT must submit documentation regarding the appropriateness of the research-based, trauma-informed assessment and programming and training for the specialized treatment needs of the client. The RRT must ensure that medically necessary care not provided by the RRT including medical services and pharmaceutical services are provided without delay for the health of the child by appropriate providers in the community. For RRT, there is at least a quarterly review of client’s treatment plan; goals and progress toward goals must be completed.
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b. Optometrists' services.
   - Provided:  ☑ No limitations  ☐ With limitations*
   - Not provided.

c. Chiropractors' services.
   - Provided:  ☑ No limitations  ☐ With limitations*
   - Not provided.

d. Other Practitioners' services.
   - Provided: Identified on attached sheet with description of limitations, if any.
   - Not provided.

7. Home Health Services
   a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.
      - Provided:  ☑ No limitations  ☐ With limitations*
   b. Home health aide services provided by a home health agency.
      - Provided:  ☑ No limitations  ☒ With limitations*
   c. Medical supplies, equipment, and appliances suitable for use in the home.
      - Provided:  ☑ No limitations  ☒ With limitations*

*Description provided on attachment.
6. Medical Care and other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law (continued).

6.b. **Optometrists’ Services**

These services are reimbursed:

1. For Medicaid-eligible Individuals under age 21, as an EPSDT service (routine eye exams including refraction and provision of eyeglasses); or
2. For Medicaid-eligible individuals over age 21, medically necessary diagnostic and treatment services provided under the scope of optometric practice in State law for symptomatic Medicaid recipients (i.e. disease, injury, illness, or other medical disorder of the eyes), excluding routine eye exams or refractions related to the provision of eyeglasses and excluding coverage of eyeglasses.

6.c. **Chiropractors’ Services**

Chiropractic services are furnished in accordance with 42 CFR 440.60(b) and include only services that are provided by a chiropractor who is licensed by the State, and consists of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform. Services may be subject to prior authorization and/or medical review, and include:

1. Evaluation and management services;
2. Diagnostic x-rays; and

Provider Qualifications: Qualified chiropractors must be licensed per Delaware licensure requirements codified in Chapter 7, Title 24 of the Delaware Administrative Code, Professions and Occupations.

6.d. **Other Practitioners’ Services**

1. Licensed Midwife services are services permitted under scope of practice authorized by state law for the licensed midwife.
2. Licensed Behavioral Health Practitioner: A licensed behavioral health practitioner (LBHP) is a professional who is licensed in the State of Delaware to diagnose and treat mental illness or substance abuse acting within the scope of all applicable state laws and their professional license. A LBHP includes professionals licensed to practice independently:
   - Licensed Psychologists
   - Licensed Clinical Social Workers (LCSWs)
   - Licensed Professional Counselors of Mental Health (LPCMHs)
   - Licensed Marriage and Family Therapists (LMFTs)
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6.d. 2. Licensed Behavioral Health Practitioner Continued:

Services which exceed the initial pass-through authorization must be approved for re-authorization prior to service delivery. In addition to individual provider licensure, service providers employed by addiction treatment services and co-occurring treatment services agencies must work in a program licensed by the Delaware Division of Substance Abuse and Mental Health (DSAMH) and comply with all relevant licensing regulations. Licensed Psychologists may supervise up to seven (7) unlicensed assistants or post-doctoral professionals in supervision for the purpose of those individuals obtaining licensure and billing for services rendered. Services by unlicensed assistants or post-doctoral professionals under supervision may not be billed under this section of the State Plan. Instead, those unlicensed professionals must qualify under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program or rehabilitation sections of the State Plan or provide services under Home and Community-based authorities.

Inpatient hospital visits are limited to those ordered by the beneficiary's physician. Visits to a nursing facility are allowed for LBHPs if a Preadmission Screening and Resident Review (PASRR) indicates it is a medically necessary specialized service in accordance with PASRR requirements. Visits to Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR) are non-covered. All LBHP services provided while a person is a resident of an Institute for Mental Disease (IMD) such as a free standing psychiatric hospital or psychiatric residential treatment facility are part of the institutional service and not otherwise reimbursable by Medicaid. Evidence-based Practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by Delaware Health and Social Services (DHSS) and/or its designee. A unit of service is defined according to the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) approved code set consistent with the National Correct Coding Initiative unless otherwise specified.
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d. Physical therapy, occupational therapy, or speech pathology and audiology services
provided by a home health agency or medical rehabilitation facility.

- Provided: ☑ No limitations ☐ With limitations*
- Not provided.

8. Private duty nursing services.

- Provided: ☑ No limitations ☐ With limitations*
- Not provided.

*Description provided on attachment.

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Information previously on page 3 of Attachment 3.1-A
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
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LIMITATIONS:

8. Private Duty Nursing Services: All requests for private duty nursing services must be prior authorized. Private duty nursing is available only for recipients who require more individual and continuous care than home health services as defined in 42 CFR 440. 70. Private Duty Nursing Services (PDN) provided in a hospital or nursing home would not be paid. This care is already covered in the fee paid to those facilities. Only PDN services provided in non-institutional settings are covered.

TN No. SP #404 Approval Date June 14, 2005
Supersedes
TN No. SP #302 Effective Date March 10, 2005
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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9. Clinic services.
   - Provided: ☑ No limitations ☑ With limitations*
   - Not provided.

10. Dental services.
    - Provided: ☐ No limitations ☑ With limitations*
    - Not provided.

11. Physical therapy and related services.
    a. Physical therapy.
       - Provided: ☑ No limitations ☑ With limitations*
       - Not provided.
    
    b. Occupational therapy.
       - Provided: ☑ No limitations ☑ With limitations*
       - Not provided.
    
    c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).
       - Provided: ☑ No limitations ☑ With limitations*
       - Not provided.

*Description provided on attachment.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic Services

Clinic services are provided consistent with the provisions of 42 CFR 440.90, including the requirement that they be operated under the direction of a physician as described in the State Medicaid Manual section 4320, and include the following:

- Medical or rehabilitation clinics excluding Mental Health clinics, which require certification by the Division of Substance Abuse and Mental Health (DSAMH) as part of the Single State Agency for Medicaid) and

- State Licensed Free Standing Surgical Centers (FSSCs) which equate to federally defined Ambulatory Surgical Centers (ACSs) using related policies for ACSs described in Sections 2265 and 2266 of the Medicare Carriers Manual.

- School-based Wellness Center Clinic Services provide primary prevention, early intervention and treatment services, including physical examinations, treatment of acute medical conditions, community referrals, counseling and other supportive services to children in school settings.
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Health care professionals that provide the above services at the SBWCs include: physicians, nurse practitioners, licensed clinical social workers, certified and licensed drug and alcohol counselors, certified sexual assault counselors and registered dieticians. Licensure requirements for each practitioner type are specified in the Title 24 of the Delaware Code, Professions and Occupations and in the Delaware Administrative Code.

10. Dental Clinic Services are only available as ESPDT services to children under age 21.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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11. Physical therapy and related services provided under 42 CFR 440.110 are limited to the following:

a. Physical therapy (PT) services are provided in order to restore functions, improve mobility, relieve pain, and to prevent or limit permanent physical disabilities and patient suffering from injuries or disease. They include such treatments as: Hot packs, Hydrocollator, Infra-Red Treatments, Gait Training, Ultrasound, Range of Motion Tests and Therapeutic Exercises. The patient must be under the care of a physician who must review the written plan of care at least every 30 days. Physical therapy services can be performed only by a qualified physical therapist or under his or her supervision. Qualified physical therapy practitioners must be licensed per Delaware licensure requirements codified in section 2600, Title 24 of the Delaware Administrative Code Regulated Professions and Occupations. The amount, frequency, and duration of the PT services must be reasonable and necessary. PT services are limited to services provided in the therapist’s office or client’s home.

b. Occupational therapy (OT) services treat individuals with a temporary or permanent mental, physical, physical, developmental, or emotional disability by means of constructive activities designed to promote the restoration of an individual’s ability to perform required daily living task and those required by the person’s particular occupational role. Occupational therapist assist individuals in performing activities of all types that are necessary in their daily living and working environments. Those activities range from using a computer, to caring for daily needs such as dressing, cooking, and eating. Physical exercises may be used to increase strength and dexterity, but they shall not be duplicated by physical therapy. Paper and Pencil exercises may be chosen to improve visual acuity and the ability to recognize or comprehend pattern. Occupational therapist may also instruct individuals in the use of adaptive equipment such as wheelchairs, splints and aids for eating and dressing. The patient must be under the care of a physician who must review the written plan of care at least every 30 days. OT services can be performed only by a qualified physical therapist or under his or her supervision.

Attachment 3.1-A
Page 4c Addendum
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Qualified occupational therapy practitioners must be licensed per Delaware licensure requirements codified in section 2000, Title 24 of the Delaware Administrative Code Regulated Professions and Occupations. The amount, frequency, and duration of the OT services must be reasonable and necessary. OT services are limited to services provided in the therapist’s office or clients home.

c. Speech/Language Pathology Services include assessing, diagnosing, treating, and helping to prevent speech, language, cognitive, communication, voice, swallowing, fluency, and other related disorders. Common treatments include: language intervention activities, articulation therapy and oral motor/feeding therapy. The patient’s condition must be such that the services required can be safely and effectively preformed only by or under the supervision of a qualified speech pathologist. The therapy must be furnished under a written plan of treatment established and signed by either a physician or therapist caring for the patient. Such services can be performed only by a qualified Speech/Language Pathologist or under his or her supervision. Qualified practitioners must be licensed per Delaware licensure requirements codified in section 3700, Title 24 of the Delaware Administrative Code, Regulated Professionals and Occupations. The amount, frequency, and duration of these services must be reasonable and necessary. Services covered under this section are limited to services provided in the therapist’s office or clients home.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
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12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a
physician skilled in diseases of the eye or by an optometrist.

   a. Prescribed drugs.
      ☒ Provided: ☐ No limitations ☒ With limitations*
      ☐ Not provided.

   b. Dentures.
      ☐ Provided: ☐ No limitations ☐ With limitations*
      ☒ Not provided.

   c. Prosthetic devices.
      ☒ Provided: ☐ No limitations ☒ With limitations*
      ☐ Not provided.

   d. Eyeglasses.
      ☐ Provided: ☐ No limitations ☐ With limitations*
      ☒ Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those
provided elsewhere in the plan.

   a. Diagnostic services.
      ☒ Provided: ☐ No limitations ☒ With limitations*
      ☐ Not provided.

*Description provided on attachment.
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LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12.a. Prescribed Drugs:

Drug Coverage

1) Drug products are covered when prescribed or ordered by a physician, or other licensed practitioner within the scope of their practice and when obtained from a licensed pharmacy. Covered drugs, as defined in Section 1927(k)(2) of the Act, are those which are prescribed for a medically accepted indication, medically necessary, and produced by any pharmaceutical manufacturer, which has entered into and complies with a drug rebate agreement under Section 1927(a) of the Act.

2) Drugs excluded from coverage by Delaware Medicaid as provided by Section 1927(d)(2) of the Act, include:

a. Drugs designated less than effective by the FDA (DESI drugs) or which are identical, similar, or related to such drugs;

b. Drugs when used to promote fertility;

c. Drugs that have an investigational or experimental or unproven efficacy or safety status;

d. Drugs when used for anorexia, weight loss or weight gain; and

3) The State will cover agents when used for cosmetic purposes or hair growth only when the state has determined that use to be medically necessary.

4) Non-covered services also include: drugs used to correct sexual dysfunction and compound drugs (compound prescriptions must include at least one medication that on its own would be a covered entity).

Quantity and Duration

1. Dosage limits: Medications are limited to a maximum dose recommended by the FDA and appropriate medical compendia described in section 1927(k) of the Social Security Act, that indicate that doses that exceed FDA guidelines are both safe and effective or doses that are specified in regional or national guidelines published by established expert groups such as the American Academy of Pediatrics, or guidelines recommended by the Delaware Medicaid Drug Utilization Review (DUR) Board and accepted by the DHSS Secretary.
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LIMITATIONS

12.a. Prescribed Drugs Continued:

2. Quantity limits are placed on therapeutic categories that will allow for coordinated care and improve outcomes. Limits exist for:
   a. Sedative hypnotics-15 doses per 30 days
   b. Triptans, acute treatment of migraines, 9 doses per 45 days
   c. Opioid analgesics-720 immediate release doses per 365 days
   d. Skeletal muscle relaxants-120 tablets/capsules per 30 days
   e. Benzodiazepines-120 tablets per 30 days
   f. Tramadol-240 tablets per 30 days
   g. Narcotic cough medications-480ml per 30 days
   h. Adjunctive anticonvulsants-240 tablets/capsules per 30 days
   i. Nebulizer solutions-3 acute exacerbations per 30 days
   j. Clients utilizing greater than 15 unique medications per 30 days
   k. Medications that are dosed once a day are limited to one dose per day unless that total dosage required is within the limits stated above and require more than one tablet/capsule to obtain the required therapeutic amount.

3. Duration of therapy
   a. Nicotine cessation products are limited to the duration that has been approved by the FDA.
   b. Palivizumab-6 months during the high viral period of the year.

4. Prescriptions are limited to a quantity not to exceed the greater of 100 dosing units or a 34-day supply except for drugs selected and received through mail order.

Prior Authorization

1. Prior authorization requirements may be established for certain drug classes or particular drugs, or a medically accepted indication for uses and doses.

2. The Drug Utilization Review Board (DUR) determines which drugs may require prior authorization. The Board assesses data on drug use in accordance with predetermined standards. The predetermined standards shall be:
   a. monitoring for therapeutic appropriateness
   b. overutilization and underutilization
   c. appropriate use of generic products
   d. therapeutic duplication
   e. drug-disease contraindications
   f. drug-drug interactions
   g. incorrect drug dosage or duration of drug treatment
   h. clinical efficacy
   i. safety
   j. medical necessity
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LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12.a Prescribed Drugs Continued:

Prior Authorization Continued

k. potential for abuse, misuse and diversion
l. experimental use opportunity, and
m. cost effectiveness relative to similar therapies

The recommendations of the Drug Utilization Review (DUR) Board shall constitute interpretive guidelines to be used in the determination whether to grant or deny prior authorization of a prescription drug. The makeup and membership authority for the DUR Board complies with 42 U.S.C. s1396r-8.

3. A request for prior authorization for covered outpatient drugs is processed within 24 hours of receipt of a completed prior authorization request from a prescribing provider by telephone, mail or electronic communication. A 72-hour supply of medically necessary covered drugs is provided in an emergency situation as mandated and pursuant to 42 United States Code s1396r-8.

Preferred Drug Lists with Prior Authorization

A process is established which utilized a preferred drug list (PDL) for selected therapeutic classes. Drugs in those classes that are not included on the PDL shall require prior authorization. A Pharmaceutical & Therapeutics (P&T) Committee, comprised of pharmacists, physicians, and community members, appointed by the Secretary, Delaware Health & Social Services, selects drugs for the PDL.

Delaware will participate in a multi-state pooling program that will negotiate supplemental rebates in addition to the federal rebates provided for in Title XIX of the Social Security Act.

Supplemental Rebate Agreements

Certain covered products in accordance with Section 1927 of the Social Security Act may not be among the baseline preferred drugs identified by the State of Delaware’s Drug Utilization Review (DUR) Board and/or the Pharmacy and Therapeutics (P & T) Committee for various therapeutic classes. The state may negotiate supplemental rebate agreements that would reclassify any drug not designated as preferred in the baseline listing for as long as the agreement is in effect.
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12.a Prescribed Drugs Continued:

Supplemental Rebate Agreements Continued

Supplemental rebate agreements are unique to each state. The Centers for Medicare and Medicaid Services (CMS) has authorized the April 7, 2005, December 20, 2005, and December 10, 2013 versions of the “Delaware State Supplemental Rebate Agreement.” These agreements were effective for drugs dispensed prior to July 1, 2016.

CMS has authorized Delaware to enter into "The Sovereign States Drug Consortium (SSDC)" Medicaid multi-State purchasing pool. The supplemental rebate agreement submitted to CMS on July 1, 2016 amends the December 10, 2013 version of the "Delaware State Supplemental Drug Rebate Agreement" authorized under Transmittal Number SPA #15-001. CMS has authorized this amended version of the "Delaware State Supplemental Drug Rebate Agreement" and the January 1, 2015 addendum to this agreement, entitled "Sovereign States Drug Consortium, Addendum to Member States Agreements". This agreement and the Addendum apply to drugs dispensed beginning July 1, 2016.

In addition the State has the following policies for the supplemental rebate program for the Medicaid population:

1. Funds received from supplemental rebate agreements will be reported to CMS. The state will remit the federal portion of any supplemental rebates collected.

2. Manufacturers with supplemental rebate agreements are allowed to audit utilization data.

3. The unit rebate amount is confidential and cannot be disclosed in accordance with Section 1927(b)(3)(D) of the Social Security Act.

4. The State of Delaware’s Division of Medicaid and Medical Assistance (DMMA) may require prior authorization for covered outpatient drugs. Non-preferred drugs are available with prior authorization.

5. The prior authorization process for covered outpatient drugs will conform to the provisions of section 1927(d)(5) of the Social Security Act.

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LIMITATIONS

12.c.  Prosthetic Devices

Prosthetic and orthotic devices, as well as other durable medical equipment and assistive technology services, are covered when documented as medically necessary.
13.a. **Diagnostic Services**

Medicaid will pay for the rental of an apnea monitor to monitor the breathing of an infant for whom a diagnosis of apneic episodes (near-miss Sudden Infant Death Syndrome) has been made.
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b. Screening services.  
☐ Provided: ☐ No limitations ☐ With limitations*  
☒ Not provided.  

c. Preventive services,  
☒ Provided: ☐ No limitations ☒ With limitations*  
☐ Not provided.  

d. Rehabilitative services.  
☒ Provided: ☐ No limitations ☒ With limitations*  
☐ Not provided.  

14. Services for individuals age 65 or older in institutions for mental diseases.  
a. Inpatient hospital services.  
☒ Provided: ☒ No limitations ☐ With limitations*  
☐ Not provided.  

b. Skilled nursing facility services.  
☐ Provided: ☐ No limitations ☐ With limitations*  
☒ Not provided.  

c. Intermediate care facility services.  
☒ Provided: ☒ No limitations ☐ With limitations*  
☐ Not provided.  

*Descriptions provided on attachment.
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13.c. Preventive Services

In accordance with section 4106 of the Affordable Care Act, Delaware Medicaid Covers and reimburses all preventative services assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF), all approved vaccines and their administration, recommended by the Advisory Committee on Immunization Practices (ACIP), and behavioral interventions to treat Autism Spectrum Disorder (ASD) without cost-sharing.

Preventative services are any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of their practice under State law and include all preventive services not otherwise covered under the State Plan pursuant to Section §1905(r)(5) of the Social Security Act, Early and Periodic Screening, Diagnostic, and Treatment Services, for other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan. Preventive Services are reimbursed according to the methodologies for services described in Attachment 4.19-B. Methods and Standards for Establishing Payment Rates – Other Types of Care, of the State Plan.

The State assures the availability of documentation to support the claiming of federal reimbursement for these preventative services.

The State assures that the benefit package will be updated as changes are made to the USPSTF and ACIP recommendation, and that the State will update the coverage and billing codes to comply with these revisions.

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13.c. Preventive Services Continued

Behavioral Services to Treat Autism Spectrum Disorder (ASD) Pursuant to Act, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services

Covered services are provided in accordance with §1905(a)(4)(B), 1905 (A)(13), and 1905(r) of the Social Security Act. Behavioral assessments and services to treat Autism Spectrum Disorder (ASD) pursuant to EPSDT are provided only to Medicaid beneficiaries under age twenty-one. Pursuant to 42 C.F.R. § 440.130(c), these services are provided as preventive services and are recommended by a physician or other licensed practitioner of the healing arts within his or her scope of practice under state law to prevent the progression of ASD, prolong life, and promote the physical and mental health and efficiency of the child.

Pursuant to section 4385 of the State Medicaid Manual, preventive services must be direct patient care provided to the child for the primary purpose of diagnosing or treating ASD, which is a set of conditions that directly affects the child’s mental and physical health.

Prior to receiving an ASD Assessment or ASD Treatment Services, the child must receive a medical/physical evaluation that indicates that ASD Assessment or ASD Treatment services are medically necessary and recognized as therapeutically appropriate. All medically necessary services for children under the age of 21 will be furnished without limitation.

Autism Spectrum Disorder (ASD) Covered Services

(1.) ASD Assessments and Support/Treatment Plans

(a.) Behavioral Assessment

Service Description: Behavior assessments must use a validated assessment instrument and can include direct observational assessment, observation, record review, data collection and analysis. Examples of behavior assessments include function analysis and functional behavior assessments. The behavior assessment must include the current level of functioning of the individual using a validated data collection method. Behavioral assessments and ongoing measurements of improvement must include behavioral outcome tools.

(1.) The behavioral assessment should be reviewed no less frequently than every six months or as behaviors or the circumstances of the child change.
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13.c. Preventive Services Continued

Behavioral Services to treat (ASD) Pursuant to Act, (EPSDT) Services Continued

ASD Covered Services Continued

(2.) Assessment Tool: Behavior Assessment practitioners must use a validated assessment tool or instrument and can include direct observational assessment, observation, record review, data collection and analysis. The Behavior Assessment must include the current level of functioning of the child using a validated data collection instrument or tool.

(b.) Behavioral Plan of Care

(1.) Service Description: The Behavioral Plan of Care is a detailed plan, based on the Behavioral Assessment of ASD treatment services specifically tailored to address each child’s adaptive and/or behavioral needs. The plan includes at least the following: measurable goals and expected outcomes to determine if ASD treatment services are effective; specific description of the recommended amount, type, frequency, setting and duration of ASD treatment services; and amount and type of recommended caregiver ongoing participation in the ASD treatment services necessary to maximize the success of the services. The service includes skill modeling, feedback, and reinforcement to family members or caregivers based on the Behavioral Plan of Care to ensure that treatment strategies outlined in the Plan are being transferred and implemented by the family or caregiver. The service is for the direct benefit of the Medicaid recipient.

(c.) Qualified Providers of ASD Assessments and Behavioral Plan of Care

(1.) The entire set of practitioner types described in section (3.) Qualified Providers, beginning on Attachment 3.1-A Page 6 Addendum 1f below, with the exception of the Registered Behavior Technician, are qualified to provide this ASD Assessments and the Behavioral Plan of Care, operating within the scope of service for his or her practice.
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13.c. Preventive Services Continued

Behavioral Services to treat (ASD) Pursuant to Act, (EPSDT) Services Continued

ASD Covered Services Continued

(2.) ASD Treatment Services

(a.) Service Description: ASD treatment services include a variety of behavioral interventions, which have been identified as evidence-based by nationally recognized research reviews and/or other nationally recognized substantial scientific and clinical evidence. These services are designed to be delivered primarily in the home or in other community settings and include any intervention supported by credible scientific and/or evidence, as appropriate to each child

(b.) ASD treatment services include, but are not limited to, the following categories of evidence-based interventions:

a. Collecting information systematically regarding behaviors, environments, and task demands (e.g., shaping, demand fading, task analysis);
b. Adapting environments to promote positive behaviors and learning while reducing negative behaviors (e.g., naturalistic intervention, antecedent based intervention, visual supports);
c. Applying reinforcement to change behaviors and promote learning (e.g., reinforcement, differential reinforcement of alternative behaviors, extinction);
d. Teaching techniques to increase positive behaviors, build motivation, and develop social, communication, and adaptive skills (e.g., discrete trial teaching, modeling, social skills instruction, picture exchange communication systems, pivotal response training, social narratives, self-management, prompting);
e. Teaching parents to provide individualized interventions for their child, for the benefit of the child (e.g., parent implemented intervention);
f. Using typically developing peers (e.g., individuals who do not have ASD) to teach and interact with children with ASD (e.g., peer mediated instruction, structured play groups); and
g. Applying technological tools to change behaviors and teach skills (e.g., video modeling, tablet-based learning software).
13.c. Preventive Services Continued

Behavioral Services to treat (ASD) Pursuant to Act, (EPSDT) Services Continued

ASD Covered Services – ASD Treatment Services Continued

(c.) Prohibited practices in the treatment of ASD include:

(1.) Aversive interventions;
(2.) Seclusion;
(3.) Denial of nutritionally adequate diet;
(4.) Chemical Restraints;
(5.) Mechanical Restraints; and
(6.) The use of Behavior Modifying Medications without a formal assessment and diagnosis of a corresponding mental health disorder by physician, advance practice nurse, or physician assistant with prescriptive authority.

(d.) ASD Service Delivery: ASD treatment services shall be rendered in accordance with the beneficiary’s treatment plan. The treatment plan shall:

(1.) Be person-centered and based upon individualized goals over a specific timeline;
(2.) Be developed by a qualified autism service provider for the specific beneficiary being treated;
(3.) Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors;
(4.) Identify long, intermediate, and short-term goals and objectives that are specific, behaviorally defined, measurable, and based upon clinical observation;
(5.) Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives;
(6.) Utilize evidence-based practices with demonstrated clinical efficacy in treating ASD, that are tailored to the beneficiary;
(7.) Ensure that services are consistent with evidenced-based ASD treatment techniques;
(8.) Clearly identify the service type, number of hours of direct service and supervision, and any recommended actions on the part of parents or guardians, if applicable, needed to achieve the plan’s goals and objectives (caregiver participation is encouraged but not required as a condition of receiving this service);
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13.c. Preventive Services Continued

Behavioral Services to treat (ASD) Pursuant to Act, (EPSDT) Services Continued

ASD Covered Services – ASD Treatment Services Continued

(d.) ASD Service Delivery Continued:

(9.) Clearly identify the frequency at which the child’s progress is reported;
(10.) Clearly identify the individual providers responsible for delivering the services;
(11.) Include case management to be provided by the ASD service provider involving individuals that are significant in the person’s life, school, state disability programs, and others as applicable; and
(12.) Include recommendations for training, support, and participation of the parent/guardian, and other persons chosen by the child as appropriate, to benefit the Medicaid eligible child, as described in the treatment plan. This recommended participation also acts as training of the caregiver for the benefit of the child and enables the caregiver to be able to reinforce the services for the child in a clinically effective manner. Caregiver participation is encouraged but not required as a condition of receiving this service.

(e.) Limitations on ASD Treatment Services: Total ASD treatment services covered under this section and recommended as part of the Behavior Support Plan or ABA Treatment Plan may only be the amount medically necessary for each child. Plans that recommend more than 40 hours per week require prior authorization.

(f.) Qualified Providers of ASD Treatment Services:

(1.) The entire set of practitioner types described in section (3.) Qualified Providers, beginning on Attachment 3.1-A Page 6 Addendum 1f below are qualified to provide ASD treatment services operating within the scope of service for his or her practice.
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13.c. Preventive Services Continued

Behavioral Services to treat (ASD) Pursuant to Act, (EPSDT) Services Continued

(3.) Qualified Providers:

Autism Spectrum Disorder services must be provided by qualified practitioners, as specified in the section below. Unlicensed practitioners may operate under the supervision of a licensed practitioner that is responsible for the work and work methods, regularly reviews the work performed, and is accountable for the results. Supervision must adhere to the requirements of the practitioner’s licensing board and the supervisory relationship must be documented in writing. Qualified practitioners may also be certified by the Behavior Analyst Certification Board (BACB) under one of the categories listed below, and must act within the scope of their certification, as determined by the BACB.

(a.) Licensed Practitioners

(1.) The following qualified licensed practitioners under Delaware or other State regulation are licensed by a state and may provide ASD services without any other certification: Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors of Mental Health (LPCMH), advanced practice nurses (APNs), medical doctors (MD and DO), physician assistants, psychiatrists, and psychologists or their assistants. Psychological assistants may only practice under the supervision of a licensed practitioner.

(b.) Unlicensed Professionals

(1.) The following unlicensed practitioners may provide ASD services under the SPA:

(a.) Board Certified Behavior Analyst ® (BCBA®) – is not required to work under the supervision of a licensed practitioner when providing ASD services within the scope of his or her practice. The Behavior Analyst Certification Board (BACB) defines the requirements of this practitioner type. The certification conferred by the BACB includes requisite coursework, supervised field experience and passage of an exam prior to issuance of the certification.

(b.) Board Certified Assistant Behavior Analyst ® (BCaBA®) - can only provide ASD services under the supervision of a BCBA®. Supervision requirements for this practitioner type are specified by the Behavioral Analyst Certification Board. The certification conferred by the BACB includes requisite coursework, supervised field experience and passage of an exam prior to issuance of the certification.
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14.c. Preventive Services Continued

Behavioral Services to treat (ASD) Pursuant to Act, (EPSDT) Services Continued

ASD Covered Services – Qualified Providers Continued

(c.) Registered Behavior Technician - can only provide ASD services under the supervision of a BCaBA® or BCBA®. Supervision requirements for this practitioner type are specified by the Behavioral Analyst Certification Board. The certification conferred by the BACB includes requisite coursework, supervised field experience and passage of an exam prior to issuance of the certification.

(d.) Psychological assistant - may only practice under the supervision of a licensed practitioner. The supervising Psychologist must register the Psychological Assistant whom he/she is supervising with the Board of Psychology, Delaware Division of Professional Regulation. The supervising licensed Psychologist must have practiced as a licensed psychologist for two years in Delaware or another jurisdiction. The supervising Psychologist must assume full professional, legal, and ethical responsibility for the services provided by the registered Psychological Assistant. As part of registration process, the supervising Psychologist is required to provide to the Board:

1. Detailed and current, written job description delineating the range and type of duties, educational practicum and clinical experience to be assigned to the Psychological Assistant;
2. Limits of the Psychological Assistant’s independent action, emergency procedures for contacting the supervising Psychologist, and the amount and type of supervision the supervising Psychologist will provide; and
3. A clear contingency plan for consultation when the licensed Psychologist is not in the office.

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15.c. **Preventive Services Continued**

**Behavioral Services to treat (ASD) Pursuant to Act, (EPSDT) Services Continued**

**ASD Covered Services – Qualified Providers Continued**

(c.) **Behavioral Plan of Care**

The practitioner who develops the Behavioral Plan of Care should be the same practitioner who performed the Behavior Assessment, except in extenuating circumstances, such as if the practitioner changed employers, moved to another geographic area, or needed to collaborate with another practitioner with different expertise.

Medicaid shall not cover program services or components of services that are of an unproven, experimental, of a research nature, or that do not relate to the child’s diagnosis, symptoms, functional limitations or medical history.
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13.d. Rehabilitative Services: 42 CFR 440 130(d)
On January 1, 2015 reimbursement and coverage of Community Support Services shall cease in the state plan.

Rehabilitative Services are limited to: 1) community support services for adults who would benefit from services designed for or associated with mental illness, alcoholism or drug dependence, excluding those services of an educational or vocational nature; and, 2) day health and rehabilitation services for adults who would benefit from services designed for or associated with the treatment of mental retardation or developmental disabilities; and, 3) crisis intervention (CI) services for adults with mental illness, alcoholism or drug dependence, excluding those services of an educational or vocational nature; and, 4) substance use disorder (SUD) treatment services for adults with alcoholism or drug dependence excluding those services of an educational or vocational nature (Note: Services for children with mental illness, alcoholism or drug dependence are more expansive and are addressed in Section 4b of the Delaware Medicaid State Plan under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

1. Community Support Services

ELIGIBLE PROVIDES
Providers are organizations certified by the Division of Substance Abuse and Mental Health in accordance with the Delaware Medical Assistance Program Medicaid Provider Manual for Rehabilitative/Community Support Service Program.

DEFINITION of COMMUNITY SUPPORT SERVICES
Community support services are medically related treatment, rehabilitative and support services provided through self-contained programs by teams of clinicians, associated clinicians and assistant clinicians under the supervision of a physician.

FREQUENCY, DURATION AND SCOPE
Community support services are provided, as medically necessary subject to the limitations of the state plan, to assist eligible persons cope with the symptoms of their illnesses, minimize the effects of their disabilities on their capacity for independent living and prevent or limit periods of hospital treatment.

Eligible recipients are Medicaid recipients who would benefit from services designed for or associated with mental illness, alcoholism or drug addiction. The provider’s physician must certify medical necessity for community support services based on completed comprehensive medical/psycho-social evaluation.
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13d. Rehabilitative Services (Continued)

QUALIFIED STAFF

Community support programs may bill Medicaid for community support services only when authorized as medically necessary by a physician and delivered by qualified staff. Services rendered by any qualified staff other than a physician must be provided under a physician's supervision as defined in the Medicaid Provider Manual for Rehabilitative/Community Support Service Programs. Component community service activities require specific staff qualifications as defined in the Medicaid Provider Manual for Rehabilitative/Community Support Service Programs. Following are illustrative definitions of staff listed as qualified to provide one or more community support service activities.

1. Physician: a person with a Medical Degree or Doctor of Osteopathy degree, who is licensed to practice Medicine in Delaware and has completed (or is enrolled in) an accredited residency training program in psychiatry, internal medicine or family practice.

2. Clinician: a person with a doctoral or master's degree in psychology, social work, nursing, rehabilitation or counseling from an accredited college or university (or a registered nurse with a certificate in mental health nursing from the American Nurses Association).

3. Associate Clinician: a person with a bachelor's degree in a human service field or a registered nurse.

4. Assistant Clinician: a person with an associate degree, a licensed practical nurse or a certified counselor lacking the academic credentials of an associate clinician.

5. Rehabilitative Services Assistant: a person with a high school diploma or GED who has received documented training that shall, at a minimum, include: 1) a complete course in medications used in the treatment used in the treatment of mental illness including side effects assigned; 2) a course in mental illness including symptoms of the major mental illnesses, mood and personality disorders; 3) a course in first aid, including CPR training.

A clinician with clinical/administrative experience in provision of community support services serves as program coordinator. A physician serves as clinical supervisor, providing direct supervision of the aspects of the program that relate to client treatment and providing clinical supervision of staff. The physician is available full- or part-time at provider sites to provide direct service, to provide direct supervision to other staff, and to participate in assessment of client needs and planning of service provision. The physician has 24-hour backup arrangements with other physicians for coverage when he/she is unavailable.
13d. **Rehabilitative Services** (Continued)

**COVERED SERVICES**

Enrolled providers may bill Medicaid for community support services when one or more of the following community support service activities are rendered to eligible recipients by qualified staff:

*Comprehensive Medical/Psychosocial Evaluation:* A multi-functional assessment of the client conducted by a physician (psychiatrist, internist or family practitioner), and clinicians under the supervision of the physician, to establish the medical necessity of provision of services by the community support service provider and to formulate a treatment plan.

The comprehensive medical/psychosocial evaluation will be conducted within 45 days of admission to the program and at least annually thereafter. It must be documented in the client's record on forms approved by the Division.

The comprehensive medical/psychosocial evaluation will include the following assessments: 1) extent and effects of drug and/or alcohol use; 2) medical systems survey; 3) medication history; 4) psychiatric history and mental status examination; 5) social history/update; 6) quality of life inventory; 7) social skills and daily living skills assessment; 8) diagnosis on all axes in accordance with DSM-III-R criteria; and 9) clinical risk factors. The evaluation will also include the formulation and review with the client of an individual treatment plan.

*Physician Services:* Services provided within the scope of practice of medicine or osteopathy as defined by State law and by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

In the context of community support service programs, physician services refer to medical or psychiatric assessment, treatment, and prescription of pharmacotherapy. Medical and psychiatric nursing services including components of physical assessment, medication assessment and medication administration provided by registered nurses and licensed practical nurses are provided under personal supervision of the physician.

*Emergency Services:* Therapy performed in a direct and face-to-face involvement with the client available on a 24-hour basis to respond to a psychiatric or other medical condition which threatens to cause the admission of the client to a hospital, detoxification or other crisis facility. Emergency services are provided by a physician, clinician, associate clinician or rehabilitative services assistant.
13d. **Rehabilitative Services** (Continued)

**COVERED SERVICES** (Continued)

*Counseling and Psychotherapy:*
Counseling is supportive psychotherapy performed as needed in a direct and face-to-face involvement with the client available on a 24-hour basis to listen to, interpret and respond to the client's expression of her/his physical, emotional and/or cognitive functioning or problems. It is provided within the context of the goals of the program's clinical intervention as stated in the client's treatment plan. Its purpose is to help the client achieve and maintain psychiatric and/or drug/alcohol-free stability. Its broader purpose is to help clients improve their physical and emotional health and to cope with and gain control over the symptoms of their illnesses and effects of their disabilities. Counseling is provided by physicians, clinicians, associate clinicians and assistant clinicians who are credentialed counselors or learning and practicing under direct supervision by a credentialed clinician.

In addition to supportive psychotherapy there are several highly specific modalities of psychotherapy, each based on an empirically valid body of knowledge about human behavior. Provision of each requires specific credentials. Although the nature of the client's needs and the specific modality of therapy determine its duration, psychotherapy has circumscribed goals, a definite schedule and a finite duration. Examples include: psychodynamic therapy, psychoeducational therapy, multi-family group therapy, and cognitive therapy. The assessments, treatment plans and progress notes in client records must justify, specify and document the initiation, frequency, duration and progress of such specialized modalities of psychotherapy.

Psychotherapy may be provided by physicians and clinicians who are credentialed in specific modalities or learning and practicing under the supervision of one who is credentialed.

*Psychiatric Rehabilitative Services:*
Rehabilitative therapy provided on an individual and small group basis to assist the client to gain or relearn skills needed to live independently and sustain medical/psychiatric stability. Psychiatric rehabilitation is provided primarily in home and community based settings where skills must be practiced. Psychiatric rehabilitative services are provided by a physician, clinician, associate clinician, assistant clinician or rehabilitative services assistant.
13d. **Rehabilitative Services**

1) **Community Support Services**

**COVERED SERVICES- continued**

*Psychosocial Rehabilitation Center Services:* Facility based, group rehabilitative therapy for clients who can not be adequately served through only individualized home and community based psychiatric rehabilitative services. Psychosocial rehabilitative therapy is provided to assist the client to gain or relearn skills needed to live independently and sustain medical / psychiatric stability. Therapy is provided in 4-hour blocks for up to five days per week at a psychosocial rehabilitation center facility. Services are provided by a physician, clinician, associate clinician, assistant clinician or rehabilitative services assistant.

*Residential Rehabilitation Services:* Facility-based, 24-hour rehabilitative therapy for clients who can not be adequately served through psychosocial rehabilitation center and/or individualized home and community based psychiatric rehabilitative services. Residential rehabilitation services are provided to assist the client to gain or relearn skills needed to live independently and sustain medical / psychosocial stability. Residential Rehabilitation Services facilities shall be required to comply with all applicable facility licensing requirements. Services are provided by a physician, clinician, associate clinician, assistant clinician or rehabilitative services assistant. Facilities providing residential rehabilitation services shall not be larger than 16-bed capacity. Room and board costs are not included in the service costs.

Services must be authorized by a physician's determination of medical necessity, must be supported by an individual treatment plan signed by the physician and must be supervised by a physician in a manner prescribed by the Medicaid Provider Manual for Rehabilitative / Community Support Service Programs.

**LIMITATIONS**

Services provided beyond 60 days following entry to the program, or the anniversary date of entry to the program, without completion of a comprehensive medical and psychosocial assessment, treatment plan and physician's certification of medical necessity are not reimbursable. Psychosocial rehabilitation center services must be re-certified by the program physician every six months.

Vocational counseling, vocational training at a classroom or job site, academic/remedial educational services and services which are solely recreational in nature are not reimbursable by Medicaid.

Services must be provided in accordance with the Medicaid Provider Manual.
13d. Rehabilitative Services:  
   1) *Community Support Services*  

   LIMITATIONS - continued  
   Services provided in an institution for mental diseases are not reimbursable.  
   Room and board services are not coverable.
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LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

13.d. Rehabilitative Services: 42CFR 440.130(d)

2. Day Health and Rehabilitation Services for Individuals with Conditions Associated with Mental Retardation Developmental Disabilities.

ELIGIBLE PROVIDERS

Providers are organizations certified by the Division of Mental Retardation (DMR) in accordance with standards established by DMR and also accredited by the Commission for Accreditation of Rehabilitation Facilities (CARF).

DEFINITION OF DAY HEALTH AND REHABILITATION SERVICES

Day health and rehabilitation services shall provide individualized activities, supports, training prevocational habilitation services, and transportation based on a written plan of care eligible persons for two or more hours per day scheduled multiple times per week. These services are intended to improve the recipient’s condition or to maintain an optimal level of functioning, as well as to ameliorate the recipient's disabilities or deficits by reducing the degree of impairment or dependency. Therapeutic consultation to service providers, family and friends of the client around implementation of the plan of care may be included as part of the services provided by the day health and habilitation program. The provider must be an approved provider of services and meet all applicable standards. Specific components of day health and rehabilitation services include the following as needed:

1. Self-care and hygiene skills;
2. Eating and toilet training skills;
3. Task learning skills;
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13.d. Rehabilitative Services: 42 CFR.440.130(d)

4. Community resource utilization skills (e.g., training in time, telephone, basic communication, money, warning sign recognition, and personal identification, etc.);
5. Environmental and behavior skills (e.g., training in punctuality, self-discipline, care of personal belongings and respect for property, and in wearing proper clothing for the weather, etc.);
6. Medication management;
7. Travel and related training to and from the training sites and service and support activities;
8. Prevocational habilitation skills;
9. Skills related to the above areas, as appropriate that will enhance or retain the recipient’s functioning.

There would be two levels of Day Health and Rehabilitation Services based on functioning levels of clients served. One level will be for clients medically involved in need of more intensive medical supports. Rates will be different between the two levels.

FREQUENCY, DURATION AND SCOPE

Community Day Health and Rehabilitation services are provided as medically necessary subject to the limitations of the State Plan, to assist eligible persons cope with mental retardation and developmental disabilities, minimize the effects of their disabilities on their capacity for independent living and prevent or limit periods of institutional treatment.

Eligible recipients are Medicaid recipients who would benefit from services designed for, or associated with the treatment of mental retardation and developmental disabilities. The amount, frequency, and necessity of services shall be documented by the interdisciplinary team based on a completed comprehensive medical/psycho-social evaluation.
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13.d. Rehabilitative Services: 42 CFR 440.130(d)

LIMITATIONS

Vocational counseling, vocational training at a classroom, or job site, academic/remedial education services and services which are solely recreational in nature are not reimbursable by Medicaid.

Units of service with individuals other than the eligible clients are not reimbursable by Medicaid.

Services delivered by telephone are not reimbursable by Medicaid.

Services must be provided in accordance with the Medicaid State Plan.

Services provided in institutions for mental retardation are not reimbursable under this section of the Medicaid Plan.

Component services of community Day Health and Rehabilitation service programs may not be sub-contracted to independent provider organizations.

REIMBURSEMENT METHODOLOGY

For reimbursement methodology, see Attachment 4.19-B, Page 16.
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13.d. Rehabilitative Services: 42 CFR 440.130(d)

3. Crisis Intervention (CI) Services for Adults with Mental Illness, Alcoholism Or Drug Dependence

Crisis Intervention (CI) Services are provided to a beneficiary who is experiencing a behavior health crisis, designed to interrupt and/or ameliorate a crisis experience including an assessment, immediate crisis resolution, and de-escalation, and referral and linkage to appropriate medically necessary behavioral health services to avoid, where possible, more restrictive levels of treatment. The goals of CI are symptom reduction, stabilization, and restoration to a previous level of functioning. All activities must occur within the context of a potential or actual behavioral health crisis. CI is a face-to-face intervention and can occur in a variety of locations, including community locations where the beneficiary lives, works, attends school, and/or socializes.

Specific activities include:
A. An assessment of risk and mental status, as well as the need for further evaluation or other mental health services. Includes contact with the client, family members, or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of an assessment and/or referral to other alternative mental health services at an appropriate level.
B. Short-term CI including crisis resolution and de-briefing with the identified Medicaid beneficiary.
C. Follow-up with the individual, and as necessary, with the beneficiary’s caretaker and/or family member(s) including follow-up for the beneficiary who is in crisis and assessed in an emergency prior to a referral to the CI team.
D. Consultation with a physician or with other qualified providers to assist with the beneficiary’s specific crisis.
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13.d. Rehabilitative Services: 42 CFR 440.130(d) Continued:

3. Crisis Intervention (CI) Services for Adults with Mental Illness, Alcoholism Or Drug Dependence Continued:

Qualified staff shall assess, refer, and link all Medicaid beneficiaries in crisis. This shall include performing any necessary assessments; providing crisis stabilization and de-escalation; development of alternative treatment plans; consultation, training and technical assistance to other staff; consultation with the psychiatrist; monitoring of beneficiaries; assessment for linkage, transfer, transport; or admission as necessary for Medicaid beneficiaries at the conclusion of the CI service. CI specialists shall provide CI counseling, on and off-site; monitoring of beneficiaries; assessment under the supervision of a certified assessor; and referral and linkage to appropriate medically necessary behavioral health services to avoid, where possible more restrictive levels of treatment. CI specialists who are nurses may also provide medication monitoring and nursing assessments. Psychiatrists in each crisis program perform psychiatric assessments, evaluation and management as needed; prescription and monitoring of medication; as well as supervision and consultation with CI program staff. Certified Peers may be utilized under clinical supervision for the activities of crisis resolution and de-briefing with the identified Medicaid beneficiary and follow-up (components B and C above).

Beneficiary Participation Criteria

These rehabilitative services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid beneficiaries. CI services must be medically necessary. The medical necessity for these rehabilitative services must be recommended by a licensed practitioner of the healing arts who is acting within the scope of his/her professional license and applicable state law to promote the maximum reduction of symptoms and restoration of a beneficiary to his/her best age-appropriate function level. Licensed practitioners of the healing arts include: Licensed Behavioral Health Practitioners (LBHPs), advanced practice nurses (APNs), nurse practitioners (NPs), and physicians. All beneficiaries who are identified as experiencing a seriously acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved to effectively resolve it are eligible.
13.d. Rehabilitative Services: 42 CFR 440.130(d) Continued:

3. Crisis Intervention (CI) Services for Adults with Mental Illness, Alcoholism Or Drug Dependence
Continued:

A beneficiary in crisis may be represented by a family member or other collateral contact who has
knowledge of the beneficiary's capabilities functioning. Beneficiaries in crisis who require this service
may be using substance during the crisis. Substance use should be recognized and addressed in an
integrated fashion as it may be add to the risk increasing the need for engagement in care. The
assessment of risk, mental status, and medical stability must be completed by a credentialed mental
health screener, Licensed Behavioral Health Practitioner (LBHP), advanced practice nurse (APN), nurse
practitioner (NP), or physician with experience regarding this specialized mental health service,
practicing within the scope of their professional license or certification. The crisis plan developed from
this assessment and all services delivered during a crisis must be by qualified staff provided under a
certified program. Crisis services cannot be denied based upon substance use. The CI specialist must
receive regularly scheduled clinical supervision from a person meeting the qualifications of a LBHP,
APN, NP, or physician with experience regarding this specialized mental health service. The
beneficiary's chart must reflect resolution of the crisis which marks the end of the current episode. If
the beneficiary has another crisis within twenty-four (24) hours of a previous episode, it shall be
considered part of the previous episode and a new episode will not be allowed.

A unit of service is defined according to the Healthcare Common Procedure Coding System
(HCPCS) approved code set unless otherwise specified.
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13.d. Rehabilitative Services: 42. CFR 440.130(d) Continued:

3. Crisis Intervention (CI) Services for Adults with Mental Illness, Alcoholism Or Drug Dependence Continued:

Provider Qualifications

Individual practitioners may be licensed as:

- Psychiatrists, Board Certified Emergency Physicians, or a physician in another area of specialty. Board Certified Emergency Physicians must also complete a required informational training. Physicians in other areas of specialty must attend four (4) hours of training and be credentialed by the Delaware Division of Substance Abuse and Mental Health (DSAMH).
- Registered Nurse.
- Advanced Practice Nurse operating in collaboration with a Delaware licensed physician
- Licensed Behavioral Health Practitioner including:
  - Licensed Psychologist
  - Licensed Clinical Social Worker (LCSW)
  - Licensed Professional Counselor of Mental Health (LPCMH)
  - Licensed Marriage and Family Therapist (LMFT)
- Licensed Physician Assistant supervised by a licensed physician.

Individual practitioners may be certified as:

- Credentialed mental health screeners who are not licensed must meet all State requirements including having two (2) years of clinical and/or crisis experience; at least a bachelors or master's degree in a mental health related field; and completing forty (40) hours of crisis services in an employed position under direct supervision of a psychiatrist or credentialed mental health screener following completion of the mental health screener training and satisfactory score on the mental health screener credentialing examination.
13.d. Rehabilitative Services: 42 CFR 440.130(d) Continued:

3. Crisis Intervention (Cl) Services for Adults with Mental Illness, Alcoholism Or Drug Dependence
Continued:

- A Certified Peer on a Cl team is an individual who has self-identified as a beneficiary or survivor of mental health and/or substance use disorder (SUD) services, is at least 21 years of age, and meets the qualifications set by the state including specialized peer specialist training, certification and registration. The training provided/contracted by the Delaware Division of Substance Abuse and Mental Health (DSAMH) shall be focused on the principles and concepts of peer support and how it differs from clinical support. The training will also provide practical tools for promoting wellness and recovery, knowledge about beneficiary rights and advocacy, as well as approaches to care that incorporate creativity. A Certified Peer must have at minimum a high school education or GED, (preferably with some college background) and be currently employed as a peer supporter in Delaware. Delaware state-approved standardized peer specialist training includes academic information as well as practical knowledge and creative activities. Each crisis program including certified peer staff is supervised by a licensed practitioner of the healing arts who is acting within the scope of his/her professional license and applicable state law.

A Crisis Intervention Specialist is an unlicensed mental health professional with a bachelors or master’s degree in a mental health related field. The Cl specialist must receive training and regularly scheduled clinical supervision from a person meeting the qualifications of a LBHP, APN, NP, or physician with experience regarding this specialized mental health service.

Provider Qualifications Continued:

Programs shall be certified by Medicaid and/or its designee. Each crisis program, is supervised by licensed practitioner of the healing arts who is acting within the scope of his/her professional license and applicable state law. A licensed practitioner of the healing arts who is acting within the scope of his/her professional license and applicable state law (e.g., Licensed Behavioral Health Practitioner (LBHP), physician, nurse practitioner (NP) or advanced practice nurse (APN) is available for consultation and able to recommend treatment twenty-four (24) hours a day, seven (7) days a week to the Cl program.
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13.d. Rehabilitative Services: 42 CFR 440.130(d) Continued:

3. Crisis Intervention (CI) Services for Adults with Mental Illness, Alcoholism Or Drug Dependence
   Continued:

   Amount, Duration and Scope:

   A unit of service is defined according to the Healthcare Common Procedure Coding System (HCPCS) approved code set unless otherwise specified. CI services by their nature are crisis services and are not subject to prior approval. CI services are authorized for no more than twenty-three (23) hours per episode. Activities beyond the twenty-three (23) hour period must be prior authorized by the State or its designee. Providers receiving referrals from emergency rooms will bill only the follow-up HCPCS codes. Service components that are not provided to, or directed exclusively toward the treatment of the Medicaid beneficiary are not eligible for Medicaid reimbursement.

   The CI services should follow any established crisis plan already developed for the beneficiary, if it is known to the team, as part of an individualized treatment plan to the extent possible. The CI activities must be intended to achieve identified care plan goals or objectives.
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13.d Rehabilitative Services: 42 CFR 440.130(d) Continued:

4. Substance Use Disorder (SUD) Treatment Services

Addiction services include:
4A. Outpatient Addiction Services
4B. Residential Addiction Services

4A. Outpatient Addiction Services

Outpatient addiction services are community-based addiction services not provided in an outpatient hospital setting and include individual-centered activities consistent with the beneficiary’s assessed treatment needs with a rehabilitation and recovery focus designed to promote skills for coping with and managing symptoms and behaviors associated with substance use disorders (SUD). These activities are designed to help beneficiaries achieve and maintain recovery from SUDs. Outpatient SUD services include medically necessary care according to assessed needs including the four (4) component activities: (1) Assessment and clinical treatment plan development – The purpose of the assessment is to provide sufficient information for problem identification, SUD treatment or referral for the beneficiary to gain access to other needed Medicaid SUD or mental health services. The treatment plan for Medicaid SUD or mental health services must be patient-centered and developed in collaboration with the patient; (2) Skill development for coping with and managing symptoms and behaviors associated with substance use disorders (SUD) such as the participant’s perspective and lack of impulse control or signs and symptoms of withdrawal; (3) Counseling to address a beneficiary’s major lifestyle, attitudinal, and behavioral problems. Counseling includes highly structured psychosocial therapy to address issues that have the potential to undermine the goals of treatment; (4) Medication Assisted Therapies (MAT) when medically necessary, including the direct administration of medication.
13.d Rehabilitative Services: 42 CFR 440.130(d) Continued:

4. Substance Use Disorder (SUD) Treatment Services

4A. Outpatient Addiction Services Continued

Outpatient activities are delivered on an individual or group basis in a wide variety of settings including site-based facility, in the community or in the beneficiary’s place of residence. These services may be provided on site or on a mobile basis as defined by Delaware Health and Social Services (DHSS) or its designee. The setting will be determined by the goal which is identified to be achieved in the beneficiary’s written treatment plan.

Outpatient services may be indicated as an initial modality of care for a beneficiary whose severity of illness warrants this level of treatment, or when a beneficiary’s progress warrants a less intensive modality of service than they are currently receiving. The intensity of the services will be driven by medical necessity. Medication Assisted Therapies (MAT) should only be utilized when a beneficiary has an established SUD (e.g., opiate or alcohol dependence condition) that is clinically appropriate for MAT.

Provider qualifications: Outpatient addiction services are provided by licensed and unlicensed professional staff, who are at least eighteen (18) years of age with a high school or equivalent diploma, according to their areas of competence as determined by degree, required levels of experience as defined by state law and regulations and approved program guidelines and certifications approved by DHSS or its designee. All outpatient substance use disorder (SUD) programs are licensed or certified under state law. Licensed practitioners under Delaware state regulation are licensed by Delaware and include Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors of Mental Health (LPCMH), Licensed Marriage and Family Therapists (LMFTs), nurse practitioners (NPs), advanced practice nurses (APNs), medical doctors (MD and DO), Licensed Chemical Dependency Professionals (LCDPs), and psychologists.
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13.d Rehabilitative Services: 42 CFR 440.130(d) Continued:

4. Substance Use Disorder (SUD) Treatment Services

4A. Outpatient Addiction Services Continued

Any staff who is unlicensed and providing addiction services must be credentialed by DHSS or its designee and/or the credentialing board or, if a Certified Recovery Coach or Credentialed Behavioral Health Technician, be under the supervision of a qualified health professional (QHP) or Clinical Supervisor. Certified and Credentialed staff under Delaware state regulation for SUD outpatient services include certified recovery coaches, credentialed behavioral health technicians, Registered Nurses and Licensed Practical Nurses, certified alcohol and drug counselor (CADC), internationally certified alcohol and drug counselor (ICADC), certified co-occurring disorders professional (CCDP), and internationally certified co-occurring disorders professional (ICCDP), and internationally certified co-occurring disorders professional diplomate (ICCDP-D).

State regulations require supervision of Certified Recovery Coaches and Credentialed Behavioral Health Technicians by QHP meeting the supervisory standards established by DHSS or its designee. A QHP includes the following professionals who are currently registered with their respective Delaware board LCSWs, LPCMHs, and LMFTs, APNs, NPs, CADCS, LCDPs, medical doctors (MD and DO), and psychologists. Clinical Supervisors includes individuals who have a Bachelor’s degree in chemical dependency, psychology, social work counseling, nursing or a related field and have either: 1) Five (5) years of related clinical experience or 2) full certification as a CADCs, ICADCs, CCDPs, ICCDPs, and ICCDP-Ds. All Clinical Supervisors must meet these requirements by January 1, 2018. The QHP or Clinical Supervisor provides clinical/administrative oversight and supervision of Certified Recovery Coaches and Credentialed Behavioral Health Technicians staff in a manner consistent with their scope of practice.
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13.d Rehabilitative Services: 42 CFR 440.130(d) Continued:

4. Substance Use Disorder (SUD) Treatment Services

4A. Outpatient Addiction Services Continued

– Recovery coaches must be trained and certified in the State of Delaware to provide services. The certification includes criminal, abuse/neglect registry and professional background checks, and completion of a State-approved standardized basic training program. Recovery coaches must self-identify as a present or former primary beneficiary of SUD services. Note: Recovery coaches within a licensed or certified residential program must provide counseling as a component of outpatient addiction services (see component activity 3 above) consistent with an approved treatment plan. Medicaid will not reimburse for 12-step programs run by recovery coaches.

– Credentialed behavioral health technicians are unlicensed professional staff who are at least 18 years of age with a high school or equivalent diploma and trained in American Society of Addiction Medicine (ASAM) level of care criteria.

– If the professional is not licensed in another jurisdiction but is applying for certification in Delaware and is currently certified by the Delaware Certification Board, Inc. (DCB), or other national certification board such as the NAADAC as either a NCAC or MAC, then the applicant must also have a criminal history record check and verify any current or previous licensure and/or certification.
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13.d Rehabilitative Services: 42 CFR 440.130(d) Continued:

4. Substance Use Disorder (SUD) Treatment Services

4A. Outpatient Addiction Services Continued

– Professionals who are certified must have documentation of a Master’s degree with graduate semester courses in counseling or related education and post-Master’s experience including supervised counseling in substance abuse counseling.

– All other unlicensed practitioners who are certified by a national body must meet the requirements for credentialed behavioral health technicians in addition to any requirements for their national certification.

All providers listed may provide any component of the outpatient SUD services consistent with State law and practice act with two exceptions: recovery coaches cannot perform assessments and all programs with MAT interventions must comply with federal and state laws regarding controlled substance prescriber availability.
13.d Rehabilitative Services: 42 CFR 440.130(d) Continued:

4. Substance Use Disorder (SUD) Treatment Services

4B. Residential Addiction Services

Residential services include individual-centered residential services consistent with the beneficiary’s assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance use disorder symptoms and behaviors. These services are designed to help beneficiaries achieve changes in their substance use disorder behaviors. Services should address the beneficiary’s major lifestyle, attitudinal, and behavioral problems that have the potential to undermine the goals of treatment. Residential SUD services include medically necessary care according to assessed needs including the four (4) component activities:

1. Assessment and clinical treatment plan development – The purpose of the assessment is to provide sufficient information for problem identification, SUD treatment or referral for the beneficiary to gain access to other needed Medicaid SUD or mental health services. The treatment plan for Medicaid SUD or mental health services must be patient-centered and developed in collaboration with the patient; (2) Skill development for coping with and managing symptoms and behaviors associated with substance use disorders (SUD) such as the participant’s perspective and lack of impulse control or signs and symptoms of withdrawal; (3) Counseling to address a beneficiary’s major lifestyle, attitudinal, and behavioral problems. Counseling includes highly structured psychosocial therapy to address issues that have the potential to undermine the goals of treatment; (4) Medication Assisted Therapies (MAT) when medically necessary, including the direct administration of medication. Residential services are delivered on an individual or group basis in a wide variety of settings including treatment in residential settings of sixteen (16) beds or less designed to help beneficiaries achieve changes in their substance use disorder behaviors.
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13.d Rehabilitative Services: 42 CFR 440.130(d) Continued:

4. Substance Use Disorder (SUD) Treatment Services

4B. Residential Addiction Services Continued

Provider qualifications: Services are provided by licensed and unlicensed professional staff, who are at least eighteen (18) years of age with a high school or equivalent diploma, according to their areas of competence as determined by degree, required levels of experience as defined by state law and regulations and departmentally approved program guidelines and certifications. All residential programs are licensed or certified under state law per Delaware Administrative Code Title 16.6001. The licensure applies to all programs providing services to beneficiaries in need of programs and services for diagnosed substance use and/or mental disorders. The licensure at a minimum requires: documentation of all insurance coverage required in regulation; the maximum client capacity requested; and a copy of the agency’s Delaware business license and home state license, when applicable. The licensure or certification also requires a description of the services to be provided by the program, including a statement of the program philosophy, goals and objectives, and a description of the methodology for each service element; and organization charts of showing incumbent names, positions, degrees and credentials (e.g., license, certification); all vacant positions; and illustrating direct and indirect reporting and supervisory relationships.

Licensed practitioners under Delaware State regulation are licensed by Delaware and include Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors of Mental Health (LPCMH), Licensed Marriage and Family Therapists (LMFTs), nurse practitioners (NPs); advanced practice nurses (APNs), medical doctors (MD and DO), Licensed Chemical Dependency Professionals (LCDPs), and psychologists. Any staff who is unlicensed and providing addiction services must be credentialed by DHSS or its designee and/or the credentialing board or, if a Recovery Coach or Credentialed Behavioral Health Technician, be under the supervision of a qualified health professional (QHP) or Clinical Supervisor.
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13.d Rehabilitative Services: 42 CFR 440.130(d) Continued:

4. Substance Use Disorder (SUD) Treatment Services

4B. Residential Addiction Services Continued

State regulations require supervision of non-credentialed staff by the QHP or Clinical Supervisor meeting the supervisory standards established by DHSS or its designee. A QHP includes the following professionals who are currently registered with their respective Delaware board LCSWs, LPCMH, and LMFTs, APNs, NPs, CADCS, LCDPs, medical doctors (MD and DO), and psychologists. Clinical Supervisors includes individuals who have a Bachelor’s degree in chemical dependency, psychology, social work counseling, nursing or a related field and have either: 1) Five (5) years of related clinical experience or 2) full certification as a CADCs, ICADCs, CCDPs, ICCDPs, and ICCDP-Ds. All Clinical Supervisors must meet these requirements by January 1, 2018. The QHP or Clinical Supervisor provides clinical/administrative oversight and supervision non-credentialed staff in a manner consistent with their scope of practice.

Certified and credentialed staff under Delaware State regulation or the regulation of the state in which the service is provided for SUD residential treatment include certified recovery coaches, credentialed behavioral health technicians, Registered Nurses and Licensed Practical Nurses, certified alcohol and drug counselor (CADC), internationally certified alcohol and drug counselor (ICADC), certified co-occurring disorders professional (CCDP), internationally certified co-occurring disorders professional (ICCDP), and Internationally certified co-occurring disorders professional diplomate (ICCDP-D). The QHP provides clinical/administrative oversight and supervision of Certified Recovery Coaches and Credentialed Behavioral Health Technicians staff in a manner consistent with their scope of practice.
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LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
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13.d Rehabilitative Services: 42 CFR 440.130(d) Continued:

4. Substance Use Disorder (SUD) Treatment Services

4B. Residential Addiction Services Continued

– Recovery coaches must be trained and certified in the State of Delaware or the state in which they provide services to provide services. Recovery coaches are at least eighteen (18) years old, and have a high school diploma or equivalent. The certification includes criminal, abuse/neglect registry and professional background checks, and completion of a State-approved standardized basic training program. Recovery coaches must self-identify as a present or former primary beneficiary of SUD services. Note: Recovery coaches within a licensed or certified residential program must provide counseling as a component of outpatient addiction services (see component activity 3 above) consistent with an approved treatment plan. Medicaid will not reimburse for twelve-step programs run by recovery coaches.

– Credentialed behavioral health technicians are unlicensed professional staff who are at least eighteen (18) years of age with a high school or equivalent diploma and trained in American Society of Addiction Medicine (ASAM) level of care criteria.
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13.d Rehabilitative Services: 42 CFR 440.130(d) Continued:

4. Substance Use Disorder (SUD) Treatment Services

4B. Residential Addiction Services Continued

– If the professional is not licensed in another jurisdiction but is applying for certification in Delaware and is currently certified by the Delaware Certification Board, Inc (DCB), or other national certification board such as the NAADAC as either a NCAC or MAC, then the applicant must also have a criminal history record check and verify any current or previous licensure and/or certification.

– Professionals who are certified must have documentation of a Master’s degree with graduate semester courses in counseling or related education and post-Master’s experience including supervised counseling in substance abuse counseling.

– All other unlicensed practitioners who are certified by a national body must meet the requirements for credentialed behavioral health technicians in addition to any requirements for their national certification.

All providers listed may provide any component of the residential SUD services consistent with State law and practice act with two exceptions: recovery coaches cannot perform assessments and all programs with MAT interventions must comply with federal and state laws regarding controlled substance prescriber availability.
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13.d Rehabilitative Services: 42 CFR 440.130(d) Continued:

4. Substance Use Disorder (SUD) Treatment Services

4B. Residential Addiont Services Continued

Addiction Services Limitations:

All addiction services are provided as part of a comprehensive specialized program available to all Medicaid beneficiaries with significant functional impairments resulting from an identified substance use disorder (SUD) diagnosis. Services are subject to prior approval, must be medically necessary and must be recommended by a licensed practitioner or physician, who is acting within the scope of his/her professional license and applicable state law, to promote the maximum reduction of symptoms and restoration of the beneficiary to his/her best age-appropriate functional level according to an individualized treatment plan.

The activities included in the service must be intended to achieve identified treatment plan goals or objectives. The treatment plan should be developed in a person-centered manner with the active participation of the beneficiary, family, and providers and be based on the beneficiary’s condition and the standards of practice for the provision of rehabilitative services. The treatment plan should identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual.
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LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

13.d Rehabilitative Services: 42 CFR 440.130(d) Continued:

4. **Substance Use Disorder (SUD) Treatment Services**

4B. Residential Addiction Services Continued

The treatment plan must specify the frequency, amount, and duration of services. The treatment plan must be signed by the licensed practitioner or physician responsible for developing the plan with the beneficiary (or authorized representative) also signing to note concurrence with the treatment plan.

The development of the treatment plan should address barriers and issues that have contributed to the need for substance use disorder (SUD) treatment. The plan will specify a timeline for reevaluation of the plan that is at least an annual redetermination. The reevaluation should involve the beneficiary, family, and providers and include a reevaluation of plan to determine whether services have contributed to meeting the stated goals. A new treatment plan should be developed if there is no measureable reduction of disability or restoration of functional level. The new plan should identify a different rehabilitation strategy with revised goals and services.

Providers must maintain medical records that include a copy of the treatment plan, the name of the beneficiary, dates of services provided, nature, content and units of rehabilitation services provided, and progress made toward functional improvement and goals in the treatment plan. Components that are not provided to, or directed exclusively toward the treatment of the Medicaid beneficiary are not eligible for Medicaid reimbursement.
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LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

13.d Rehabilitative Services: 42 CFR 440.130(d) Continued:

4. Substance Use Disorder (SUD) Treatment Services

4B. Residential Addiction Services Continued

Services provided at a work site must not be job task oriented and must be directly related to treatment of a beneficiary’s behavioral health needs identified in the treatment plan. Any services or components of services, the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of a beneficiary receiving covered services (including housekeeping, shopping, child care, and laundry services), are non-covered. Services cannot be provided in an institution for mental disease (IMD) with more than sixteen (16) beds.

Room and board is excluded from addiction services rates. Delaware residential placement under the American Society of Addiction Medicine (ASAM) criteria requires prior approval and reviews on an ongoing basis as determined necessary by the State Medicaid Agency or its designee to document compliance with the placement standards.

A unit of service is defined according to the Healthcare Common Procedure Coding System (HCPCS) approved code set per the national correct coding initiative unless otherwise specified for licensed practitioners to utilize the Current Procedural Terminology (CPT) code set.
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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
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15.a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

- Provided: ☑ No limitations ☐ With limitations*
- Not provided.

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

- Provided: ☑ No limitations ☐ With limitations*
- Not provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

- Provided: ☑ No limitations ☐ With limitations*
- Not provided.

17. Nurse-midwife services.

- Provided: ☑ No limitations ☐ With limitations*
- Not provided.

18. Hospice care (in accordance with section 1905(o) of the Act).

- Provided: ☑ No limitations ☐ Provided in accordance with section 2302 of the Affordable Care Act
- With limitations* ☐ Not provided.

*Description provided on attachment.
Hospice Services

Hospice services will be provided in accordance with Sections 4305 through 4307 of the State Medicaid Manual.

An additional per diem amount will be paid to the hospice provider for routine home care and continuous home care days for hospice care that is furnished to an individual living in a NF, ICF/MR or ICF/IMD. That amount will be 95% of the Medicaid reimbursement level for the individual hospice patient and for the nursing facility in which the hospice patient is residing.

The Medicare reimbursement cap will not be applied to Medicaid hospice providers.

Dually eligible beneficiaries must elect the Medicare hospice benefit at the same time that the Medicaid hospice benefit is elected in order to assure that Medicaid is the secondary payor.
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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
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19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).
   - Provided  □ With limitations*
   - Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.
   - Provided:   □ With limitations*
   - Not provided.

20. Extended services for pregnant women

   c. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.
      - Additional coverage++

   d. Services for any other medical conditions that may complicate pregnancy.
      - Additional coverage++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment
20.a.&b. Limits on Extended Services to Pregnant Women

Those services normally covered by Medicaid for all eligibles are available to pregnant women.

In addition, the following services are available with prior authorization:

- Nutrition assessment, counselling, and education.
- Nursing assessment, education and referral to needed medical services.
- Social services as medically necessary to assure that home, family, community and environmental issues are not complicating the pregnancy.

Extended services to pregnant women will include the above services when given as part of a medical service provided by agencies organized, and licensed by the State of Delaware, to provide medical care.

Prior authorization will be based on complicating medical and social problems that would have a negative impact on the outcomes of the pregnancy.
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21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act)

- Provided: ☒ No limitations ☐ With limitations*
- ☐ Not provided.

22. Respiratory care services (in accordance with section 1902 (e) (9) (A) through (C) of the Act).

- ☐ Provided: ☐ No limitations ☐ With limitations*
- ☒ Not provided.

23. Pediatric or family nurse practitioners' services.

- ☒ Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

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| Supersedes | | | |
| TN No. SP | #312 | Effective Date | December 1, 1996 |

Information previously on pages 8 and 8a of Attachment 3.1-A.
LIMITATIONS:

23.a The Delaware Medicaid program does not cover any procedure which is considered experimental by the Medicare program with the exception of transplants as defined on ATTACHMENT 3.1-A, Page 1 Addendum.
24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.
   - ☑ Provided: ☐ No limitations ☑ With limitations*
   - ☐ Not provided.

b. Services of Christian Science nurses.
   - ☐ Provided: ☐ No limitations ☐ With limitations*
   - ☑ Not provided.

c. Care and services provided in Christian Science sanitoria.
   - ☐ Provided: ☐ No limitations ☐ With limitations*
   - ☑ Not provided.

d. Nursing facility services for patients under 21 years of age.
   - ☑ Provided: ☐ No limitations ☐ With limitations*
   - ☐ Not provided.

e. Emergency hospital services.
   - ☑ Provided: ☐ No limitations ☐ With limitations*
   - ☐ Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.
   - ☐ Provided: ☐ No limitations ☐ With limitations*
   - ☑ Not provided.

*Description provided on attachment.
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24.a. Transportation for medical services is provided in two ways:

   a) As an administrative service through contractual arrangements /intradepartmental
      agreements. Transportation provided as an administrative service includes:
      
      i. Non-Emergency transportation through contractual broker arrangements.

   b) As an optional medical service through direct vendor payment. Transportation provided as an
      optional medical service includes:
      
      i. Emergency transportation, and
      ii. Services provided outside the broker’s contractual obligation.

24.f. Personal Care Services

Coverage for Personal Care Services (PCS) described below will sunset on December 31, 2015 as
coverage of PCS will be provided under the Home Health Services benefit.

Eligible recipients of personal care are Medicaid recipients who are disabled by mental illness, alcoholism,
or drug addiction as defined in the Medicaid Provider Manual for Community Support Service Programs.

Persons eligible to provide personal care services are those who are qualified as an Assistant Clinician as
defined in the Medicaid Provider Manual for Community Support Service Programs.

The recipient’s physician must certify medical necessity for personal care services based on a completed
comprehensive medical/psycho-social evaluation and treatment plan as defined in the Medicaid Provider
Manual for Community Support Service Programs.
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SECTION 3 – SERVICES: GENERAL PROVISIONS

3.1 Amount, Duration, and Scope of Services

Medicaid is provided in accordance with the requirements of section 1902(a), 1902(e), 1903(i), 1905(a), 1905(p), 1905(r), 1905(s), 1906, 1915, 1916, 1920, 1925, 1929 and 1933 of the Act; section 245A(h) of the Immigration and Nationality Act; and 42 CFR Parts 431, 440, 441, 442 and 483.

A. Categorically Needy

24. Any other medical care, and other type of remedial care recognized under State law, specified by law Secretary (in accordance with section 1905(a)(28) of the Social Security Act and 42 CFR 440.170).

a. Transportation (provided in accordance with 42 CFR 440.170 as an optional medical service) excluding “school-based” transportation.

[ ] Not provided.
[ ] Provided without a broker as an optional medical service:

(If state attests “Provided without a broker as an optional medical service” then insert supplemental information.)

Describe below how the transportation program operates including types of transportation and transportation related services provided and any limitations. Describe emergency and non-emergency transportation services separately. Include and interagency or cooperative agreements with other Agencies or programs.

[ ] Non-emergency transportation is provided through a brokerage program as an optional medical service in accordance with 1902(a)(70) of the Social Security Act and 42 CFR 440.170(a)(4).
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(If the State attests that non-emergency transportation is being provided through a brokerage program then insert information about the brokerage program.)

The department’s Medicaid non-emergency medical transportation (NEMT) program is a result of a Request for Proposal (RFP) that was developed as part of a cost containment measure and to increase efficiency. The Department has established a risk-based contract with a broker to coordinate the provision of NEMT with transportation providers. The actual transportation services under the RFP are provided through subcontracts between the broker and transportation providers. The broker is responsible for the administration and provision of NEMT in each of the three counties in Delaware. The approach allows for the extensive coordination of trips appropriate use of funds.

The state assures it has established a non-emergency medical transportation program in accordance with 1902(a)(70) of the Social Security Act in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirement of 45 CFR 92.36 (b)(i).

1. The State will operate the broker program without the requirements if the following paragraphs of section 1902(a):

- (1) state-wideness (indicate areas of State that are covered)
- (10)(B) comparability (indicate participating beneficiary groups)
- (23) freedom of choice (indicate mandatory population groups)

All Medicaid recipients covered under Delaware’s Medicaid State Plan, excluding Qualified Medicare Beneficiaries, Specified Low Income Medicare Beneficiaries and Qualifying Individuals and eligible for the non-emergency medical transportation benefit. Recipients are restricted to using the statewide broker and the provider assigned by the broker for the recipient’s trip.
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SECTION 3 – SERVICES: GENERAL PROVISIONS

(2). Transportation services provided will include:

☒ wheelchair van

☒ taxi

☒ stretcher car

☒ bus passes

☒ tickets

☒ secured transportation

☒ other transportation (if checked described below other transportation.)

May include commercial air transportation for a Medicaid covered service not available in Delaware.

(3). The State assures that transportation services will be provided under contract with a broker who:

i. is selected through a competitive bidding process based on the State’s evaluation of the broker's experience, performance, references, resources, qualifications, and costs:

ii. has oversight procedures to monitor beneficiary access and complaints and ensures that transportation is timely a transport personnel are licensed qualified, competent and courteous:
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(iii) is subject to regular auditing and oversight by the State in order to ensure the quality and
timeliness of the transportation services provided and the adequacy of beneficiary access to
medical care and services:

(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the
Secretary shall establish (based on prohibitions on physician referrals under Section 1877 and such
other prohibitions and requirements as the Secretary determines to be appropriate.)

(4) The broker contract will provide transportation to the following categorically needy
mandatory populations:

- Low-income families with children (section 1931)
- Deemed AFDC-related eligibles
- Poverty-level related pregnant women
- Poverty-level infants
- Poverty-level children 1 through 5
- Poverty-level children 6-19
- Qualified pregnant women AFDC-related
- Qualified children AFDC-related
- IV-E foster children and adoption assistance children
- TMA recipients (due to employment) (section 1925)
- TMA recipients (due to child support)
- SSI recipients

(5) The broker contract will provide transportation to the following categorically needy
optional populations:

- Optional poverty-level-related pregnant women

- Optional poverty-level-related infants
SECTION 3 – SERVICES: GENERAL PROVISIONS

- Optional targeted low income children
- Non IV-E children who are under State adoption assistance Agreements
- Non IV-E independent foster care adolescents who were in foster care on their 18th birthday
- Individuals who meet income and resource requirements of AFDC or SSI
- Individuals who would meet the income & resource requirements of AFDC if child care cost were paid from earnings rather than by a State agency
- Individuals who would be eligible for AFDC if State plan had been as broad as allowed under Federal law
- Children aged 15-20 who meet AFDC income resource requirements
- Individuals who would be eligible for AFDC or SSI if they were not in a medical institution
- Individuals infected with TB
- Individuals screened for breast or cervical cancer by CDC program
- Individuals receiving COBRA continuation benefits
- Individuals in special income level group, in medical institution for at least 30 consecutive days, with gross income not exceeding 300% of SSI income standard
SECTION 3 – SERVICES: GENERAL PROVISIONS

- Individuals receiving home and community based waiver services who would only be eligible under State plan if in a medical institution *(only covers provision of NEMT to this population to and from standard Medicaid covered services allowable under State Plan)*

- Individuals terminally ill if in a medical institution and will receive hospice care

- Individuals aged or disabled with income not above 100% FPL

- Individuals receiving only an optional State supplement in a 209(b) State

- Individuals working disabled who buy into Medicaid (BBA working disabled group)

- Individuals working disabled who buy into Medicaid under TWWIIA Basic Coverage Group

- Employed medically improved individuals who buy into Medicaid under TWWIIA Medical Improvement Group

- Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids).
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SECTION 3 – SERVICES: GENERAL PROVISIONS

(6) Payment Methodology

(A) The State will pay the contracted broker by the following method:
   - (i) risk capitation
   - (ii) non-risk capitation
   - (iii) other (e.g., brokerage fee and direct payment to providers) (If checked described any other payment methodology)

(B) Who will pay the transportation provider?
   - (i) Broker
   - (ii) State
   - (iii) Other (if checked describe who will pay the transportation provider)

(C) What is the source of the non-Federal share of the transportation payments?

Describe below the source of the non-Federal share of the transportation payments proposed under the State plan amendment. If more than one source exist to fund the non-Federal share of the transportation payment, please separately identify each source of non-Federal share funding.

The State of Delaware provides funding for the non-Federal share of the Department’s Delaware Medicaid Assistance Program (DMAP) non-emergency medical transportation (NEMT) service.
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SECTION 3 – SERVICES: GENERAL PROVISIONS

- (D) The State assures that no agreement (contractual or otherwise) exist between the State or any form of local government and the transportation broker to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly). The assurance is not intended to interfere with the ability of a transportation broker to contract for transportation services at a lesser rate and credit any savings to the program.

- (E) The States assures that payments proposed under the State plan amendment will be made directly to transportation providers and that the transportation provider payment are fully retained by the transportation providers and no agreement (contractual or otherwise) exists between the State or local government and the transportation provider to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly).

(7) The broker is a non-governmental entity:

- The broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial relationship as described at 440.170(a)(4)(ii).

- The broker is itself a provider of transportation or subcontracts with or refers to an entity with which it has a prohibited financial relationship and:

  - Transportation is provided in a rural area as defined at 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

  - Transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

  - The availability of other non-governmental Medicaid participating providers or other determined by the State to be qualified is insufficient to meet the need for transportation.
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☐ (8) The broker is a governmental entity and provides transportation itself or refers to or subcontracts with another governmental entity for transportation. The governmental broker will:

☐ Maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program.

☐ Document that with respect to each individual beneficiary’s specific transportation needs, the government provider is the most appropriate and lowest cost alternative.

☐ Document that the Medicaid program is paying no more for fixed route public transportation then the rate charged to the general public and more for public para-transit services than the rate charged to the other State human services agencies for the same service.

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SECTION 3 – SERVICES: GENERAL PROVISIONS

(9) Please describe below how the NEMT brokerage programs operates. Include the services that will be provided by the broker. If applicable, describe any services that will not be provided by the broker and name the entity that will provide these services.

Delaware’s Non-Emergency Medical Assistance Program (NEMT) are defined as necessary services provided to Delaware Medical Assistance Program (DMAP) clients to ensure reasonable access to and from medical services. Necessary NEMT is defined as the least expensive mode of transportation available that is appropriate to the medical and or functional needs of the client.

NEMT services include wheelchair van, non-emergency ambulance, public transportation, car/station wagon, minivan, taxi and mileage reimbursement. NEMT services do not include emergency ambulance transportation or transportation to or from non-medical services.

The broker is responsible for management of overall day-to-day operations necessary for the delivery of NEMT services and the maintenance of appropriate records and systems of accountability to report to the Division of Medicaid and Medical Assistance (DMMA). The broker ensures the overall delivery of NEMT services including vehicle, driver, and attendant requirements and performance. The broker verifies eligibility, coordinates trips, reimburses transportation providers, responds to complaints and employs accountability measures to ensure effective utilization of expenditures. The broker maintains an ongoing quality assurance plan to support the provision of high-quality NEMT service. DMMA provides oversight for the NEMT program, including overall program management, determination of policy, monitoring of service and quality assurance to ensure the consistent delivery of quality NEMT services allowing recipients’ timely access to health care services.

Each month the Delaware Medicaid Management Information System (MMIS) transmits and eligibility file for all DMAP clients who are eligible for transportation services through the transportation broker. The broker is required to use and maintain the eligible file to verify client eligibility for services.
The broker is reimbursed a monthly capitation rate for each eligible client. The broker must accept the per member per month (PMPM) rate reimbursement as payment in full, inclusive of all administrative cost and transportation cost. From the PMPM payment made to the broker by DMMA, the broker will pay transportation providers in accordance with terms of the service agreement between the broker and each transportation provider.

The broker ensures the provision of service delivery to meet the needs of receipts for routinely scheduled trips, standing orders and urgent trips. NEMT service is available twenty-four hours a day (24) seven days a week (7) including weekends and holidays. The clients must contact the broker to request NEMT services at least two (2) work days prior to the non-urgent, scheduled appointment. Advance scheduling will be mandatory for all NEMT services except urgent care, follow-up appointments and unscheduled pick-up when the timeframe does not allow advance scheduling.

Out-of-state transportation is provided to DMAP client to secure to necessary medical care. There are two categories of out-of-state transportation services, Exceptional Transportation and Specialized Transportation:

1) Exceptional Transportation is defined as an NEMT service that is provided to DMAP clients within fifty (50) miles of Delaware’s border. All Exceptional Transportation is arranged through the broker and is included in the monthly capitation rate.

2) Specialized Transportation is defined as an NEMT services that is provided to DMAP clients in excess of fifty (50) miles of Delaware’s border. It is the responsibility of the broker to arrange for the delivery of all Specialized Transportation services. The broker is required to coordinate with and obtain prior authorization from DMMA for all Specialized Transportation service. The broker is expected to find the most cost-effective means of transportation considering the client’s needs. The state will reimburse the broker on a fee-for-service basis for the cost of this service.
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24. Certified Nurse Practitioner Services, whether or not the nurse practitioner operates in association with, or under the supervision or, a physician or other health care provider, effective July 1, 1990.
25. (i) Licensed or Otherwise State-Approved Freestanding Birthing Center Services

☑ Provided:  ☐ No limitations  ☑ With limitations*
☐ Not provided.

Please describe any limitations: *See ATTACHMENT 3.1-A Page 11 Addendum*

25. (ii) Licensed or Otherwise State-Recognized covered professionals in the Freestanding Birthing Center Services

☑ Provided:  ☐ No limitations  ☑ With limitations* (please describe below)
☐ Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations: *See ATTACHMENT 3.1-A Page 11 Addendum*

Please check all that apply:

☑ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

☑ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife).*

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.)*

*Licensed Midwife
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25. Licensed or Otherwise State-Approved Freestanding Birth Center Services

(a) Subject to the specifications, conditions, limitations, and requirements established by the single state agency or its designee, birth center facility services, under this State Plan, are limited to birth centers licensed by the State of Delaware and in compliance with regulations found in the Delaware Administrative Code or other legally authorized licensing authority under applicable state laws.

(b) Birth center facility services are those services determined by the attending physician (MD or DO) or certified nurse-midwife (CNM) or licensed midwife to be reasonable and necessary for the care of the mother and newborn child following the mother's pregnancy. The center and attending physician or CNM or licensed midwife must be licensed at the time and place the services are provided. Reimbursable services are limited to services provided by the birthing center during the labor, delivery, and postpartum periods.

(c) Services provided by a physician or CNM or licensed midwife are not considered to be birth center services by the Delaware Medical Assistance Program.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY:  **DELAWARE**

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplemental 2 Attachment 3.1-A.

   X  Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

   ___ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

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TN No. SPA#  #11-010 Approval Date  February 28, 2012
Supersedes
TN No. New Effective Date  October 1, 2011
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<th>Citation(s)</th>
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<tbody>
<tr>
<td>1935(d)(l)</td>
<td>Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.</td>
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The Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B, effective January 1, 2006.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY:  DELAWARE

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED
OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

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<tr>
<th>Citation(s)</th>
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<tbody>
<tr>
<td>1927(d)(2) and 1935(d)(2)</td>
<td>1. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit-Part D.</td>
</tr>
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</table>

- The following excluded drugs are covered:
  - (a) agents when used for anorexia, weight loss, weight gain (see specific drug categories below)
  - (b) agents when used to promote fertility (see specific drug categories below)
  - (c) agents when used for cosmetic purposes or hair growth (see specific drug categories below)
  - (d) agents when used for the symptomatic relief cough and colds (see specific drug categories below)
  - (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride (see specific drug categories below)
  - (f) nonprescription drugs (see specific drug categories below)
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY:  **DELAWARE**

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

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<td>1927(d)(2) and 1935(d)(2)</td>
<td>(g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)</td>
</tr>
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<td></td>
<td>(The Medicaid agency lists specific category of drugs below)</td>
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<tr>
<td></td>
<td>(a) Agents when used for anorexia, weight loss, weight gain: Megestrol Acetate, Somatropin, Lipase Inhibitor. Products in these categories require prior authorization.</td>
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<td></td>
<td>(d) Agents when used for the symptomatic relief cough and colds: Antihistamines, Antitussive, Decongestants, and Expectorants.</td>
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<tr>
<td></td>
<td>(e) Prescription vitamins and mineral products, except prenatal vitamins and fluoride: Single entity vitamins, Multiple vitamins w/minerals, Nicotinic acid, Calcium salts, and Dialysis replacement products</td>
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TN No. SPA#  
Supersedes  #13-001  
TN No. SPA#  #14-005  
Approval Date  April 24, 2014  
Effective Date  January 1, 2014
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: DELAWARE

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

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<td>1927(d)(2) and 1935(d)(2)</td>
<td>CONTINUED</td>
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(f) Nonprescription drugs: Analgesic oral and rectal; Heartburn; Antiflatulents; Antidiarrheals, Antinauseants; Cough & Cold, oral; Cough & Cold, topical; Contraceptive Drugs; Laxatives & Stool Softeners; Lice Control Preparations; Nasal Drug Preparations; Nicotine Cessation Preparations; Ophthalmic Drug Preparations: Topical Anesthetics; Topical Antibacterials; Topical/Vaginal Fungicidals; and Digestive Enzymes.

No excluded drugs are covered.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: DELAWARE

CASE MANAGEMENT SERVICES

A. Target Group:

B. Areas of State in which services will be provided:

☐ Entire State.

☐ Only in the following geographic areas (authority of section 1915(g)(1) of Act is invoked to provide services less than Statewide):

C. Comparability if Services

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☐ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

E. Qualification of Providers:

---

TN No. SP# #250 Supersedes HCFA ID: 1040P/0016P Approval Date December 23, 1987
TN No. # NEW Effective Date July 1, 1987
D. Definition of Services:

Case management of high risk pregnant women must include at least the following components:

**NUTRITION**
- nutrition assessment and counseling
- WIC – Food Stamps application assistance
- infant feeding, breast feeding, child care information classes

**SOCIAL WORKER**
- counseling, access to needed services to resolve problems such as with education, creditors, mental health;
- referrals to child watch, child abuse help groups; parenting skills
- long-term planning for self sufficiency through employment/training/education/referrals following delivery;
- substance abuse counseling;
- stop smoking clinic referral and assistance in attending;
- referral to genetic screening and counseling services.

**NURSING**
- weekly/monthly health assessment by RN with report of suspected problem to attending physician;
- Education on appropriate pregnancy topics; childbirth, newborn care (anticipating guidance).

**OUTREACH**
- contact client prior to pre-natal visit (phone/home visit);
- arrange transportation and babysitting, especially to assure all medical appointments are kept;
- accompany client to meetings, appointments as necessary;
- follow up to reschedule missed appointments;
- act as translator;
- facilitate implementation of goals of the care plan as directed by professional staff.

**POST PARTUM**
Continue services and resolve problems in 60 day post partum period including pregnancy prevention, infant care, assisting clients to plan for self sufficiency through referral to appropriate employment and training counseling services.
E. Qualification of Providers:

Qualified providers of case management services for high risk pregnant women will be those that can provide all of the service components described in item D on page 1a, and who have staff or contractual arrangements to make up a case management team as defined below:

Qualifications of Case Management Team Members

**NUTRITION**

shall be a Registered Dietitian of Nutritionist.

**SOCIAL WORKER**

shall be an employee with a Bachelors of Arts or Bachelors of Science degree in social work, counseling or related social services field.

**NURSING**

shall be a Registered Nurse licensed to practice in the State of Delaware.

**OUTREACH**

these members shall be experienced para-professionals operating under the supervision of the professional staff.

**CLERICAL/SUPPORT**

contractor shall have adequate clerical support staff to track, file, type, etc. all necessary documentation required to the case management team.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY:  DELAWARE

F. The State assures that the provision of case management services will not restrict an individual’s free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: DELAWARE

I. Eligibility
The State determines eligibility for PACE enrollees under rules applying to community groups.

A. ☐ The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. Spousal impoverishment eligibility rules will apply. The applicable groups are:

* Individuals receiving services under this program are eligible under the following eligibility groups:

  - A Special Income Level equal to 250% of the SSI Federal Benefit (FBR) (42 CFR 435.236)

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State’s Medicaid plan.)

B. ☒ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II – Compliance and State Monitoring of the PACE Program.)

C. ☐ The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State’s approved HCBS waiver(s).
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: DELAWARE

Regular Post Eligibility

1. ___ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee’s income.

(a). Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:
   (A.) Individual (check one)
   1. ___ The following standard included under the State plan (check one):
      (a) _____SSI
      (b) _____Medically Needy
      (c) _____The special income level for the institutionalized
      (d) _____Percent of the Federal Poverty Level: _________%
      (e) _____Other (specify):________________________
   2. ___The following dollar amount: $________
      Note: If this amount changes, this item will be revised.
   3. ___The following formula is used to determine the needs allowance:

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 1 and 3.

B.) Spouse only (check one)
   1. ___ SSI Standard
   2. ___ Optional State Supplement Standard
   3. ___ Medically Needy Income Standard
   4. ___ The following dollar amount: $________
      Note: If this amount changes, this item will be revised.
   5. ___ The following percentage of the following standard that is greater than the standards above: ____ % of ___ standard.
   6. ___ The amount is determined using the following formula:
   7. ___ Not applicable (N/A)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: DELAWARE

Regular Post Eligibility Continued

(C) Family (check one):
1. ____ AFDC need standard
2. ____ Medically needy income standard

The amount specified below 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 of the medically needy income standard established under 435.811 for a family of the same size.

3. ____ The following dollar amount: $_______
   Note: If this amount changes, this item will be revised.
4. ____ The following percentage of the following standard that is not greater than the standards above: ____ % of ____ standard.
5. ____ The amount is determined using the following formula: ________________________________
6. ____ Other: ________________________________
7. ____ Not applicable (N/A).

(2). Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

2. ____ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee’s income.

(a) 42 CFR 435.735 – State using more restrictive requirements then SSI.

1. Allowances for the needs of the:
   A. Individual (check one)
      1. The following standard included under the State plan (check one):
         (a) ____ SSI
         (b) ____ Medically Needy
         (c) ____ The special income level for the institutionalized
         (d) ____ Percent of the Federal Poverty Level: __%
         (e) ____ Other (specify): ________________________________
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: DELAWARE

2. ___ The following dollar amount: $ __
   Note: If this amount changes, this item will be revised.
3. ___ The following formula is used to determine the needs allowance:

   ________________________________________________________________

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):
   1. ___ The following standard under 42 CFR 435.121:
       ________________________________________________________________
   2. ___ The Medically needy income standard
       ________________________________________________________________
   3. ___ The following dollar amount: $ __
       Note: If this amount changes, this item will be revised.
   4. ___ The following percentage of the following standard that is not greater than the standards above: ___% of ___ standard.
   5. ___ The amount is determined using the following formula:
       ________________________________________________________________
   6. ___ Not applicable (N/A)

(C.) Family (check one):
   1. ___ AFDC need standard
   2. ___ Medically needy income standard

   The amount specified below 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 435.811 for a family of the same size.

   3. ___ The following dollar amount: $ __
       Note: If this amount changes, this item will be revised.
   4. ___ The following percentage of the following standard that is not greater than the standards above: ___% of ___ standard.
   5. ___ The amount is determined using the following formula:
       ________________________________________________________________
   6. ___ Other
   7. ___ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: DELAWARE

Spousal Post Eligibility

3. State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:
   1. Individual (check one)
      (A)______ The following standard included under the State plan

      (check one):
      1. _____ SSI
      2. _____ Medically Needy
      3. _____ The special income level for the institutionalized
      4. _____ Percent of the Federal Poverty Level: ________%
      5. _____ Other (specify): ___________________________

      (B)______ The following dollar amount: $____________
      Note: If this amount changes, this item will be revised.

      (C)______ The following formula is used to determine the needs allowance:

      ______________________________________________________

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

_________________________________________________________

_________________________________________________________
II. Rates and Payments

A. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1. **X** Rates are set at a percent of fee-for-service cost
2. ____ Experience-based (contractors/State’s cost experience or encounter date) (please describe)
3. ____ Adjusted Community Rate (please described)
4. ____ Other (please describe)

*See Pages 7 and 8 for description of rate setting methodology

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

Mercer Government Human Services Consulting
2325 East Camelback Road, Suite 600
Phoenix, Arizona 85016
Attention: Frederick P. Gibison, Jr.
1.602. 522. 6526

C. The State will submit all capitated rates to the CMS Regional Office for prior approval.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: DELAWARE

CAPITATED RATE METHODOLOGY

Base Data Source and Analysis

The PACE rates are based on the Upper Payment Limit (UPL) methodology. The historical fee for service target population data is extracted for claims and eligibility for more than one year. PACE eligibility populations used to develop the PACE UPLs are individuals enrolled in home and community based waivers (HCBS) and individuals in nursing facilities. These two populations serve as the basis upon which the PACE UPLs are developed.

Claims and eligibility data are gathered for both Medicaid-only individuals receiving the aforementioned services and also those individuals fully dually eligible for Medicaid and Medicare Parts A/B/D. Historical FFS data is compiled by date of service for the applicable year from the State's MMIS and eligibility system. Data for clients in the aforementioned two groups who are not eligible to enroll in PACE (e.g. those under age 55) are excluded from the database. The PACE UPLs include payment for all covered Medicaid services as well as Medicare coinsurance and deductible payments for full dual eligible clients. The final UPLs are developed for two rating groups: Dual Eligible - Age 55+ and Medicaid-only Age 55+.

The FFS data used in the analysis is reviewed for reasonableness to be (or as necessary adjusted to be) appropriate for UPL development as described in the most current version of the CMS PACE checklist.

- Claims expenditures for the PACE-equivalent population include Medicaid paid amounts increased by applicable patient liability and co-payments paid by recipients.
- Data for partial dual eligible populations were specifically excluded from the analysis, as they are not entitled to Medicaid services.
- Claims for services that are not covered services under PACE are not included.

Adjustments to Develop the UPL

The prospective UPL is subject to the following adjustments;

- Base Data Adjustments: The historical FFS base data are adjusted to comply with the requirements in the PACE UPL checklist and to ensure that the UPLs reflect what otherwise would have been paid under the State plan if participants were not enrolled in PACE (e.g., FFS pharmacy rebates, completion factors, copayments and patient liability).
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: DELAWARE

CAPITATED RATE METHODOLOGY (cont’d)

- Prospective Trend: Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor is necessary to estimate the cost of health care services in a defined contract period. As part of the UPL development for the PACE program, annual per-member-per-month (PMPM) trend rates by consolidated COS are developed. The base data is trended forward to the midpoint of the contract period.
- Programmatic Changes: Programmatic changes recognize the impact of changes to benefits, eligibility or State reimbursement that take place between the base period and the projection period.
- State Administrative Costs: An estimate of the State’s FFS administrative costs is included in the UPL development process.

PACE Capitation Rates

The State will ensure compliance with 42 CFR 460.182(b) by assuring that the PACE capitation rates will be a fixed percentage, of less than 100 percent, of the respective PACE UPL amounts. This percentage will consider differences between the FFS population from which the PACE UPLs were built and the expected enrollment in the PACE plans including relative acuity and the impact of better care management/care coordination.
III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: DELAWARE

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): 

1. Inpatient hospital services other than those provided in an institution for mental diseases.
   - Provided: [ ] No limitations [ ] With limitations*

2. a. Outpatient hospital services.
   - Provided: [ ] No limitations [ ] With limitations*

   b. Rural health clinic services and other ambulatory services furnished by rural health clinic.
   - Provided: [ ] No limitations [ ] With limitations*

3. Other laboratory and x-ray services.
   - Provided: [ ] No limitations [ ] With limitations*

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older
   - Provided: [ ] No limitations [ ] With limitations*

   b. Early and periodic screening, diagnostic treatment services for individuals under 21 years of age, and treatment of conditions found.

   c. Family planning services and supplies for individuals of childbearing age.
   - Provided: [ ] No limitations [ ] With limitations*

*Description provided on attachment.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: DELAWARE

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _______________________

5.a. Physicians services, whether furnished in the office, the patient’s home, a hospital, a nursing facility, or elsewhere.

☐ Provided: ☐ No limitations ☐ With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

☐ Provided: ☐ No limitations ☐ With limitations*

*Description provided on attachment.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: DELAWARE

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _______________________

19. Case management services and Tuberculosis related services
   a. Case management services as defined in, and to the group specified in, Supplement 1 to
      ATTACHMENT 3.1-A (in accordance with section 1905 (a)(19) or section 1915(g) of the
      Act.
         ☐ Provided: ☐ No limitations ☐ With limitations*
   b. Special tuberculosis (TB) related services under section 1902 (z)(2)(F) of the Act.
      ☐ Provided: ☐ No limitations ☐ With limitations*

20. Extended Services for pregnant women
   a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy
      ends and any remaining days in the month in which the 60th day falls.
      ☐ Provided ☐ Additional Coverage++
   b. Services for any other medical condition that may complicate pregnancy.
      ☐ Provided: ☐ No limitations ☐ With limitations*

21. Certified pediatric or family nurse practitioners' services
   ☐ Provided: ☐ No limitations ☐ With limitations ☐ Not Provided

++ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.)
and limitations on them, if any, that are available as pregnancy-related services or services
for any other medical condition that may complicate pregnancy.

*Description provided on attachment

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: DELAWARE

STANDARDS AND METHODS OF ASSURING HIGH QUALITY CARE

Methods of assuring high quality care vary with the type of service. Each month there is a random sample of bills for physician’s services. Half of the sample questionnaires are mailed directly to the recipient, and half are completed by a Division worker following an interview with the recipient. The Utilization Review Committee is used for hospital care. Nursing Home Care is reviewed at least annually by a medical review and by periodic reports to the Medical Services Unit at more frequent intervals.

Pharmaceuticals Services are reviewed by the Pharmaceutical Consultant.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: DELAWARE

METHODS OF PROVIDING TRANSPORTATION

Transportation is provided statewide through a brokerage program as an optional medical service in accordance with 1902(a)(70) of the Social Security Act. 42 CFR 440.170(a)(4) and all other requirements relating to Medicaid services.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: DELAWARE

STANDARDS FOR THE COVERAGE OF ORGAN AND TISSUE TRANSPLANT SERVICES

Coverage of Transplant Services
The following types of medically necessary organ and tissue transplantation procedures are covered as specified in the Delaware Medical Assistance Program (DMAP) Provider Specific Policy Manuals:

- Heart
- Heart/Lung
- Liver
- Pancreas
- Kidney
- Intestinal (small bowel)
- Cornea
- Bone Marrow and Peripheral Blood Stem Cell
- Any other transplants Delaware Medicaid determine to be added to the list of medically necessary organ and tissue transplantation procedures.

Coverage is limited to transplant services that are specified in the Delaware Medical Assistance Program (DMAP) Provider Specific Policy Manuals. Additionally, the criteria for determining a recipient’s clinical eligibility for transplantation are specified in the DMAP Manuals, as well. The Delaware Medical Assistance Program Provider Specific Policy Manuals, including all updates to the manuals, are available on the DMAP website at: [http://www.dmap.state.de.us/downloads/manuals.html](http://www.dmap.state.de.us/downloads/manuals.html).

Experimental and/or investigational Services
Services considered experimental and/or investigational are not a benefit of the Delaware Medical Assistance Program.

Transplant Criteria
Reimbursement will be made for medically necessary transplant services provided to an eligible Delaware Medicaid recipient.

Prior Authorization
All transplants require prior authorization. Specific prior authorization requirements, including the Prior Authorization Request Form, may be found in the Delaware Medical Assistance Program Provider Manuals located on: [http://www.dmap.state.de.us/downloads/manuals.html](http://www.dmap.state.de.us/downloads/manuals.html)

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<th>TN No. SPA#</th>
<th>14-011</th>
<th>Approval Date</th>
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<tr>
<td>TN No. SP#</td>
<td>250</td>
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Standards for Coverage of Organ And Transplant Services

The Following standards and criteria must be met before transplantation services are payable under the Delaware Medical Assistance Program:

**Facility** - The transplant facility must meet the requirements contained in Section 1138 of the Social Security Act, Hospital Protocols for Organ Procurement and Standards for Organ Procurement Agencies. The transplant facility performing the transplant must have approval for performing the surgery through the Certification of Need (CON) process and must supply Supporting documentation of this.

In accordance with Section 4201 of the State Medicaid Manual, the Delaware Assistance Program shall apply the following standards for coverage for all transplantation services:

1. Transplant services are provided only when medically necessary;
2. Similarly situated individuals are treated alike;
3. Any restriction, on the facilities or practices or practitioners which may provide such procedures, is consistent with the accessibility of high quality care to individuals eligible for the procedures under the State plan; and,
4. Services are reasonable in amount, duration, and scope to achieve their purpose.
Delaware's ACIST (Assertive Community Integration Support Team) program supports individuals who have a Severe and Persistent Mental Illness (SPMI) and an intellectual and developmental disabilities (I/DD) or Autism using a comprehensive, holistic, multi-disciplinary team-based approach to crisis intervention, intensive case management, behavior analysis, psychiatric supports and monitoring of medical conditions. The ACIST Health Home program design uses a whole-person approach to supports and services for individuals with dual diagnosis (SPMI & I/DD) while ensuring strong integration across behavioral health, somatic health and long-term supports and services. The ACIST program is tailored to individuals with chronic conditions of SPMI and I/DD who may require additional and/or different services or modalities to ensure effective intervention. The goals of the ACIST Health Home are:

- To lessen or eliminate critical health and safety issues that each individual member might experience, working toward preventing or mitigating these signs, symptoms, and/or social issues that could lead to crisis situations and the need for hospitalization or re-hospitalization
- To provide transitional support and post psychiatric hospitalization follow along that will assist the individual in ameliorating the effects of their mental health condition and dual diagnosis and prevent avoidable readmissions
- To improve the overall medical and physical health of the individual
- To meet basic human needs and enhance quality of life
- To improve the person's opportunity to be successful in social and employment roles and activities
- To increase active participation in the person's community
- To partner with families, support systems and/or significant other in supporting the individual's recovery

### Federal Budget Impact and Statute/Regulation Citation

#### Federal Budget Impact

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<th>Federal Fiscal Year</th>
<th>Amount</th>
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<td>$436050</td>
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<tr>
<td>Second 2020</td>
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#### Federal Statute / Regulation Citation

Section 1902(a) of the Social Security Act and 42 CFR 447

Supporting documentation of budget impact is uploaded (optional).
Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | DE2018MS0002O | DE-18-0006 | Assertive Community Integration Support Team

Package Header

- Package ID: DE2018MS0002O
- SPA ID: DE-18-0006
- Submission Type: Official
- Approval Date: 1/15/2019
- Initial Submission Date: 10/18/2018
- Superseded SPA ID: N/A
- Effective Date: N/A

Governor's Office Review

- No comment
- Comments received
- No response within 45 days
- Other
## Submission - Public Comment

**MEDICAID | Medicaid State Plan | Health Homes | DE2018MS0002O | DE-18-0006 | Assertive Community Integration Support Team**

### Package Header

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<td>Approval Date</td>
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<td>Superseded SPA ID</td>
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**SPA ID** DE-18-0006  
**Initial Submission Date** 10/18/2018  
**Effective Date** N/A

**Name of Health Homes Program**  
Assertive Community Integration Support Team

### Indicate whether public comment was solicited with respect to this submission.

- [ ] Public notice was not federally required and comment was not solicited
- [ ] Public notice was not federally required, but comment was solicited
- [ ] Public notice was federally required and comment was solicited

### Indicate how public comment was solicited:

- [ ] Newspaper Announcement

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<tr>
<th>Name of Paper</th>
<th>Date of Publication</th>
<th>Locations covered</th>
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<tbody>
<tr>
<td>State News</td>
<td>9/3/2018</td>
<td>Kent and Sussex Counties</td>
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</table>

- [ ] Publication in state's administrative record, in accordance with the administrative procedures requirements
- [ ] Email to Electronic Mailing List or Similar Mechanism
- [ ] Website Notice
- [ ] Public Hearing or Meeting

- [ ] Other method

### Upload copies of public notices and other documents used

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<td>8/23/2018 3:51 PM EDT</td>
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<tr>
<td>284899-1 DHSS- Home Health</td>
<td>9/5/2018 12:06 PM EDT</td>
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<td>Public Notice Newspaper September 3 2018 (002)</td>
<td>9/7/2018 9:05 AM EDT</td>
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<tr>
<td>DRR Public Notice</td>
<td>10/2/2018 3:23 PM EDT</td>
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- [ ] Other method

### Upload with this application a written summary of public comments received (optional)

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<tr>
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### Indicate the key issues raised during the public comment period (optional)

- [ ] Access
- [ ] Quality
- [ ] Cost
- [ ] Payment methodology
- [ ] Eligibility
- [ ] Benefits
- [ ] Service delivery
- [ ] Other issue

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**Attachment 3.1-H**
Submission - Tribal Input
MEDICAID | Medicaid State Plan | Health Homes | DE2018MS0002O | DE-18-0006 | Assertive Community Integration Support Team

Package Header

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<td>Superseded SPA ID</td>
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Name of Health Homes Program
Assertive Community Integration Support Team

One or more Indian health programs or Urban Indian Organizations furnish health care services in this state

☐ Yes
☐ No
The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.
Health Homes Intro

Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

Assertive Community Integration Support Team

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

Delaware's ACIST (Assertive Community Integration Support Team) program supports individuals with Severe and Persistent Mental Illness (SPMI) and Intellectual and Developmental Disabilities (I/DD) and/or Autism to receive a comprehensive, holistic team-based approach to crisis intervention, intensive case management, behavior analysis, psychiatric supports and monitoring of medical conditions in a multidisciplinary model. The ACIST Health Home program is designed to provide a whole-person approach to supports and services to individuals with dual diagnosis and to ensure strong integration across behavioral health, somatic health and long-term supports and services. The ACIST program is tailored to individuals with chronic conditions of SPMI and I/DD who may require additional and/or different services or modalities to ensure effective intervention. The goals of the ACIST Health Home are:

a) To lessen or eliminate critical health and safety issues, that each individual client might experience, toward preventing or mitigating these signs, symptoms, and/or social issues that could lead to crisis situations and the need for hospitalization or re-hospitalization
b) To provide post psychiatric hospitalization follow along that will assist the individual in ameliorating the effects of their mental health condition and dual diagnosis
c) To improve the overall medical and physical health of the individual
d) To meet basic human needs and enhance quality of life
e) To improve the person's opportunity to be successful in social and employment roles and activities
f) To increase active participation in the person's community
g) To partner with families and/or support systems in supporting the individual's recovery

The health home providers will be designated ACIST entities meeting rigorous provider qualifications, including demonstrated experience working with the target population. The program will operate in a fee-for-service service delivery system, utilizing a per-member-per-month payment.

General Assurances

- The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- The state provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.
Health Homes Geographic Limitations

Health Homes services will be available statewide
Health Homes services will be limited to the following geographic areas
Health Homes services will be provided in a geographic phased-in approach
Health Homes Population and Enrollment Criteria

Categories of Individuals and Populations Provided Health Homes Services

The state will make Health Homes services available to the following categories of Medicaid participants:

- [x] Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- [ ] Medically Needy Eligibility Groups
Health Homes Population and Enrollment Criteria

The state elects to offer Health Homes services to individuals with

- Two or more chronic conditions
- Mental Health Condition
- Substance Use Disorder
- Asthma
- Diabetes
- Heart Disease
- BMI over 25
- Other (specify)

<table>
<thead>
<tr>
<th>Name</th>
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<tr>
<td>Two or more chronic conditions</td>
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Specify the conditions included
<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
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| Severe and Persistent Mental Illness      | "1" below must be met, in addition to either "2", "3", or "4":  
1. Designated Mental Illness: The individual meets the criteria in the current DSM. Has a psychiatric diagnosis other than alcohol or drug disorders, organic brain syndromes, developmental disabilities or social conditions. ICD-Coding Manual psychiatric categories and codes that do not have an equivalent in DSM are also included mental illness diagnoses.  
And  
2. SSI or SSDI due to Mental Illness: The individual is currently enrolled in SSI/SSDI due to a designated mental illness.  
Or  
3. Extended Impairment in Functioning due to Mental Illness: Documentation that the individual has experienced two of the following four functional limitations due to a designated mental illness over the past 12 months on a continuous or intermittent basis:  
   i. Marked difficulties in self-care (personal hygiene, diet, and clothing, avoiding injuries, securing health care or complying with medical advice).  
   ii. Marked restriction of activities of daily living (maintaining a residence, using transportation, day to day money management, accessing community services).  
   iii. Marked difficulties in maintaining social functioning (establishing and maintaining social relationships, interpersonal interactions with primary partner, children or other family members, friends, neighbors, social skills, compliance with social norms, appropriate use of leisure time).  
   iv. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner (ability to complete tasks commonly found in work settings or in structured activities that take place in home or school settings, individuals may exhibit limitations in these areas when they repeatedly are unable to complete simple tasks within an established time period, make frequent errors in tasks, or require assistance in the completion of tasks).  
Or  
4. Reliance on Psychiatric Treatment, Rehabilitation and Supports: A documented history shows that the individual at some prior time met the threshold for 3 (above), but the symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. Medication refers to psychotropic medications which may control certain primary manifestations of mental disorder; e.g. hallucinations, but may or may not affect functional limitations imposed by the mental disorder. Psychiatric rehabilitation and supports refer to highly structured and supportive settings which may greatly reduce the demands placed on the individual and thereby, minimize overt symptoms and signs of the underlying mental disorder. |
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<tr>
<td>Intellectual and Developmental Disability (including autism)</td>
<td>Requires a diagnosis of an intellectual developmental disability (including brain injury), autism spectrum disorder or Prader-Willi Syndrome assigned in the developmental period and also documented functional limitations. The diagnosis of Intellectual or Developmental Disability is determined by a licensed psychologist, certified school psychologist or a licensed physician who practices psychiatry who certifies that the individual/applicant has significantly sub-average intellectual functioning and meets the following criteria: An adaptive behavior composite standard score of 2 or more standard deviations below the mean; or a standard score of two or more standard deviations below the mean in one or more component functioning areas (ABAS: Conceptual, Social; Practical: VABS: Communication; Daily Living Skills, Social).</td>
</tr>
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</table>

- One chronic condition and the risk of developing another
- One serious and persistent mental health condition
Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home:

- Opt-In to Health Homes provider
- Referral and assignment to Health Homes provider with opt-out
- Other (describe)

Describe the process used

Members will initially be identified via multiple streams to include but not be limited to: self-referral, community navigators, support coordinators, professionals supporting individuals in day or residential services, medical and psychiatric professionals, hospitals, and psychiatric facilities.

Reciprocal coordination will occur between Health Home and corresponding DSAMH (Division of Substance Abuse and Mental Health) services to include the DSAMH Eligibility and Enrollment Unit regarding individuals referred to either program who may be more effectively served within another program.

Enrollment will take place once application is received and all relevant medical and psychiatric documentation has been reviewed to confirm the qualifying diagnoses.

Individuals will be advised of their referral to the Health Home, and will be informed of all available options for services so that they can make an informed decision as to whether they will elect to remain in or opt out of the Health Home.

Enrollment is complete upon submission of qualifying diagnoses and consent for treatment has been signed. Consent for release of information will authorize sharing of information between identified service providers, the State, applicable Managed Care Organizations (MCO's) and other fee for service providers.

The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Homes benefit or to change Health Homes providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individuals of the Health Homes benefit and their rights to choose or change Health Homes providers or to elect not to receive the benefit.
### Types of Health Homes Providers

- Designated Providers

- Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

  - [ ] Physicians
  - [ ] Clinical Practices or Clinical Group Practices
  - [ ] Rural Health Clinics
  - [ ] Community Health Centers
  - [ ] Community Mental Health Centers
  - [ ] Home Health Agencies
  - [ ] Case Management Agencies
  - [ ] Community/Behavioral Health Agencies
  - [ ] Federally Qualified Health Centers (FQHC)
  - [ ] Other (Specify)

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<thead>
<tr>
<th>Provider Type</th>
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<tr>
<td>Provider Type</td>
<td>Description</td>
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<td>---------------</td>
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</tr>
<tr>
<td>Certified ACIST Health Home Providers</td>
<td>Certified by the Division of Developmental Disabilities as a qualified provider of Health Home Services. Certified ACIST Health Home providers meet rigorous standards of clinical and operational proficiency, including meeting specified staffing arrangements, response capabilities, fiscal accountability and solvency. Must adhere to all standards, policies, and guidelines in the State of Delaware Program Contract including: The Contractor agrees to adhere to the requirements of DHSS Policy Memorandum # 46 (responding to reportable incidents/allegations), and Divisional procedures regarding the reporting and investigation of suspected abuse, neglect, mistreatment, misappropriation of property and significant injury of residents/clients receiving services, including providing testimony at any administrative proceedings arising from such investigations. Contractor shall conduct child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del. Code Section 708; and 11 Del. Code Sections 8563 and 8564. Contractor shall not employ individuals with adverse registry findings in the performance of contract. The Contractor agrees that professional sta employed in the execution of this contract shall be state licensed, certified, or registered in their profession as required by state law. Must adhere to all standards in the Delaware's ACIST Health Home State Plan Amendment All ACIST providers must agree to accept the terms and conditions under the Medicaid provider contract as a condition of enrollment to provide services. DDDS will initially and on ongoing basis certify that the Health Home provider qualifies with the Health Home Provider criteria.</td>
</tr>
</tbody>
</table>

### Provider Infrastructure

**Describe the infrastructure of provider arrangements for Health Home Services**

Each Certified ACIST Health Home Provider must maintain the following minimum standards. ACIST services teams will be based on a 50 person program with sta to client ratio of 1:10. ACIST services will be provided statewide by the designated providers. The average numbers of full-time employees (FTEs) for each level of sta reflected for each ACIST team are below.

**Position Requirements**

- **Team Leader**: 1 FTE Master's level clinician- oversees program delivery and operation
- **Prescriber (Psychiatrist or Psychiatric Nurse Practitioner)**: 1 PT @ 25 hours per week; Initial appointments 30-45 minutes; 15 minute med checks for each individual once per month; participation in daily and team meetings. Note: the prescriber is a pivotal team member assisting with crisis response, however, his/her direct services are billed through the Medicaid State Plan.
- **Registered Nurse (RN)**: 1FTE: follow up on medical and psychiatric appointments; assist prescriber with monthly appointments; attend daily meetings; attend team meetings as needed.
- **Case Manager/Behavior Analyst (CM/BA) (Bachelor's degree or higher; background and experience writing and/or working with behavior plans.)**: 2 FTE coordinate psychiatric and medical appointments; educate families about Mental Health diagnosis; develop treatment plan with individual; work with individual, residential sta, families to understand reasons for interventions on the behavior plan and how to properly use interventions; participate in daily meetings and team meetings.
- **Master's Level Clinician**: 1 FTE (can be an additional Behavior Analyst); attend daily meetings; attend team meetings; provide individual and/or family therapy two times per month (more frequently if needed); participate in the development of treatment and behavior plans;

As demonstrated above, Delaware’s health home program will use a comprehensive team of medical, mental health, developmental disability, social services, and other disciplines to ensure that enrollees receive needed medical, behavioral, developmental disability supports, including community based crisis prevention and response services. These supports are either provided directly by the designated health home provider or the health home provides needed linkages to all supports and services, in accordance with the individual’s overarching person-centered plan. All team members will be responsible for communication on the individual's status, treatment options, actions taken and outcomes as a result of any intervention. All members of the team are also responsible for ensuring that all care and support provided is person-centered, culturally competent and linguistically capable.

To ensure the ongoing caliber of health home services, the State will maintain a highly collaborative and coordinated working relationship with each designated provider through regular, frequent communication and feedback. The state will also provide ongoing opportunities for continuous learning and best practice identification for all health home provider entities.

**Supports for Health Homes Providers**

Describe the methods by which the state will support providers of Health Homes services in addressing the following components
1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services.
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines.
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
4. Coordinate and provide access to mental health and substance abuse services.
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care.
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families.
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services.
8. Coordinate and provide access to long-term care supports and services.
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services.
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate.
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Description
The state provides ongoing and regular technical assistance, sufficient resources, and partnership with all elements noted above.
1. Detailed provider manuals and protocols delineating all expectations and practice guidelines;
2. Specifications for all required quality reporting;
3. Access to and training on state-specified information technology;
4. Introductions and follow up to ensure effective relationship establishment with all related provider types within the state; and,
5. Any as-needed and ad-hoc supports needed by the provider to ensure their effective execution of the Health Home.

The state will provide ongoing monitoring and swift interventions to ensure continuous high quality health home services.

Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows:

The following requirements apply to the provision of services for all Certified ACIST Health Home Providers:

1. Services will maintain best practice guidelines for SPMI and IDD/Autism including integration of CMS' definition of community inclusion and must adhere to all applicable requirements set forth by the State of Delaware.
2. Health Home shall have sufficient clinical, administrative and information technology infrastructure to ensure that it is capable of meeting standards.
3. The majority of services will be provided in the home and community where the individual lives rather than in an office, unless requested by the individual and substantiated in the individual record.
4. An appropriate level of supports will be provided to each individual; with frequency and duration of each contact being provided at a level specific to the individual's need as specified in the treatment plan.
5. Housing options for the individuals served must meet criteria established by the state as appropriate and meet all required licensing and certification requirements as necessary.
6. A team approach will be utilized in which all team members are familiar with the needs of each individual served by the team and are capable of providing the appropriate treatment interventions to them when called upon to do so.
7. Multiple team members will interact with each individual supported in any given day/week/month across agency and family settings.
8. The team will have daily meetings at which time each individual's needs are reviewed and treatment strategies are delineated and treatment plans updated, as required by clinical and professional determinations in accordance with the individual's person-centered plan.
9. The teams will have responsibility for acute crisis services, by providing 24 hour coverage with staff being available either by phone or in person, as appropriate, to help diffuse crisis situations and maintain community status. The contactor is not permitted to use automated phone trees as its answering service. The goal of 24 hour coverage is to intervene during acute crisis situations to reduce or eliminate the need for hospitalization.
10. The team will maintain an effective working relationship with the state's Division of Substance Abuse and Mental Health's Mobile Crisis Unit in order to respond to calls for individuals who are ACIST members and/or are being seen by the ACIST provider.
11. Health home provider will develop and implement a Quality Improvement Program designed to ensure services are consistently delivered to individuals in accordance with the Health Home services and in alignment with best practice guidelines. The program will also assure that services are based on a recovery model, person centered, and trauma informed. Results of QI activities will be written and submitted to the state on a monthly basis.
12. The health home provider will comply with all record reporting systems required and provided by the state including automated client record keeping system.
Health Homes Payment Methodologies

The State’s Health Homes payment methodology will contain the following features:

- Fee for Service
  - Individual Rates Per Service
  - Per Member, Per Month Rates
  - Fee for Service Rates based on:
    - Severity of each individual's chronic conditions
    - Capabilities of the team of health care professionals, designated provider, or health team
    - Other
- Comprehensive Methodology Included in the Plan
- Incentive Payment Reimbursement
- PCCM (description included in Service Delivery section)
- Risk Based Managed Care (description included in Service Delivery section)
- Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

The payment will be based on the costs to operate a fully functioning ACIST team with the composition specified in the SPA. The fee schedules available on the DMAP website at: http://www.dmap.state.de.us/downloads/feeschedules.html
Health Homes Payment Methodologies

Agency Rates

Describe the rates used
- FFS Rates included in plan
- Comprehensive methodology included in plan
- The agency rates are set as of the following date and are effective for services provided on or after that date
Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates
2. Please identify the reimbursable unit(s) of service
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
4. Please describe the state's standards and process required for service documentation, and
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
   - the frequency with which the state will review the rates, and
   - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description

1. The Delaware ACIST service will be a Per Member Per Month (PMPM) rate as allowed under the Health Home (HH) service model. The rate includes the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Salary models were built using FTE and salary information across benchmark data provided by:
- Bureau of Labor and Statistics (BLS)
- Another respondent to the pilot demonstration RFP; and
- the pilot demonstration, another agency who had bid for the pilot demonstration, and wage data from the Bureau of Labor and Statistics.

The staffing plan and respective FTEs for each ACIST team were initially established by DDSS in the RFP for the ACIST pilot and are also codified in the SPA. These specifications were determined to be necessary for the successful operation of the ACIST program, with considerations for expected member acuity and minimum levels of service. Salaries for all position types were compared across the three data sources. The annual salary costs used for the rate were the average of the three benchmarks with similar titles and position descriptions. The $47,150 established for Team Leader is an average of salary specified for the pilot vendor, the other bidder that was not selected, and BLS classification of “Social and Community Service Managers”. The $23,960 established for Psychiatric Nurse Practitioner is an average of the pilot agency, the non-selected RFP bidder and the 95th percentile of the BLS classification of “Nurse Practitioner”. The $28,200 established for Registered Nurse is an average of the pilot agency, the non-selected vendor, and the BLS classification “Registered Nurse”. The $39,040 established for Case Manager is an average of Case Manager for the pilot agency, Case Manager for the non-selected bidder and the BLS classification “Substance Abuse, Behavioral Disorder, and Mental Health Counselors”. The $49,369 established for Licensed Clinician is an average of Licensed Clinician for the pilot agency, Master’s Prepared Clinician for the non-selected bidder and the BLS classification “Mental Health and Substance Abuse Social Worker”. The $225,907 established for Psychiatrist is an average of Psychiatrist for the pilot vendor, the Director of Reintegration Services for the non-selected bidder and the BLS classification of “Psychiatrist”. The $31,795 established for Administrative Assistant is an average of Administrative Assistant for the pilot vendor, Administrative Assistant for the non-selected bidder and the BLS classification “Administrative Assistant”.

Transportation costs were calculated using different vehicle estimates as a benchmark for determining the annual cost of vans and sedans involved with necessary transportation to/from/of members for program activities. Costs for vehicles were estimated using values obtained from Kelley Blue Book for used 2016 vehicles in the Delaware area. Repair and Maintenance cost was estimated at 10% of the value of the vehicle. Insurance costs were estimated at $2,000 per vehicle, and due to the high need for transportation as part of this program, mileage was estimated at 15,000 miles per vehicle. In total, 4 vehicles were allocated for client transportation for each ACIST team including; three sedans and one van, for a total annual cost of $37,128.

Payroll Taxes and Fringe Benefit cost was estimated at the national average Taxes and Fringe rate of 31.70% as per BLS. The ACIST program also incorporates administration and general at 21.01% of direct personnel costs, upon DHSS recommendation. This is consistent with the budget proposals received from the pilot vendor and the non-selected vendor.

1. Per member per month rate.
2. HH providers must deliver at least three (3) of the six defined core HH services within the calendar month to the eligible HH beneficiary in order to receive a PMPM payment for an eligible HH beneficiary, a HH provider must inform the HH beneficiary about available HH services, receive the beneficiary’s consent to receive HH services, and begin the development of a care plan. The development of the care plan will follow standards for Comprehensive Care Management described in the SPA. This activity is tracked through the Electronic Health Record (EHR). Each of the six core services has a list of activities within that service that the Support Coordinator/Community Navigator will check on a monthly basis. HH providers will submit claims via MMIS using a designated coding for health home services. Any other State Plan Medicaid services delivered by a HH will be claimed fee for service separate and distinct from the Health Home monthly service.
3. Any claim for HH services shall be supported by written documentation in the EHR. Minimum documentation requires that HH provider document HH activity under any of the six core health home services it has delivered that month, including Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care from Inpatient to Other Settings, Individual and Family Support, or Referral to Community and Social Support Services. Documentation must include the service, frequency, duration and actions taken by the HH staff and the response of the recipient and any progress towards stated outcome(s). Documentation will be reviewed within the EHR by the assigned Support Coordinator/Community Navigator on a monthly basis. All claims for health home services will be subject to regular audits to ensure that Medicaid payments made to HH providers are consistent with efficiency, economy and quality of care, and in accordance with federal and state conditions of payment.
4. Rates will be considered for rebasing after each fiscal year, with a minimum of a rebased rate every three years.
   a. During annual rate reviews, the State will assess utilization levels and quality improvement metrics to determine the quality of services and the need for rate adjustments.
   b. Factors such as cost of living and cost inputs from additional ACIST providers and teams will also be considered.
Health Homes Payment Methodologies

Package Header

Package ID  DE2018MS0002O  SPA ID  DE-18-0006
Submission Type  Official  Initial Submission Date  10/18/2018
Approval Date  1/15/2019  Effective Date  10/1/2018
Superseded SPA ID  new  User-Entered

Assurances

The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Delaware will ensure non-duplication between Health Home benefits and State Plan and Medicaid HCBS services through person-centered planning practices. All underlying state plan benefits including those available to a child through EPSDT will be billed separately and directly by appropriate provider. In addition, individuals receiving health home benefits who are also enrolled in Delaware’s HCBS Lifespan Waiver (CMS Control Number DE0009) will be ineligible to also receive the included HCBS waiver services of behavior analysis and nurse consultation. Individuals receiving health home benefits may not receive services through the Delaware Promise program as authorized through the state’s approved 1115 demonstration program except to the extent that those services are over and above that which is available under the ACIST program.

The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

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No items available
Health Homes Services

Service Definitions

Provide the state’s definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition

Comprehensive Care Management (CCM) in ACIST Health Homes will include the development of a treatment plan for areas impacted by the individual’s mental health condition, consistent with the individual’s DDDS person centered plan, for service provision based upon a comprehensive history and ongoing monitoring of:

i. Psychiatric history, status, and previous diagnosis
ii. IDD/Autism functional assessment
iii. Individual outcomes as stated by the individual
iv. Housing and living situation
v. Vocational, educational, and social interests and capacities
vi. Self-care abilities
vii. Family and social relationships
viii. Family education and support needs
ix. Physical health
x. Alcohol and drug use
xi. Legal situation
xii. Personal and environmental resources

Assessments will be completed within 30 days of admission. Individual goals, psychiatric evaluation and treatment will be reevaluated every 6 months. Treatment plans should also be reevaluated any time a client experiences a significant life-event (e.g. hospitalization, death of a close friend or family member, significant changes in medications, etc.). Treatment plans will be strength-based, person-centered and will reflect individual preferences and key personal objectives. The plans will reflect a trauma informed approach to supports.

CCM will also ensure the implementation of the treatment plan, including the seamless coordination of all health home functions and facilitating any necessary linkages to supports and services necessary for its effective implementation.

For individuals in ACIST Health Homes also receiving 1915(c) Lifespan Waiver services, the treatment plan will be incorporated into the individuals’ person-centered Life Span plan, and the health home team will be an integral partner in the shaping and delivery of services to ensure seamless integration across the spectrum of supports available to the individuals served.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

ACIST Health Home providers will utilize electronic health records as required by the State of Delaware, enabling the integration of key health, social, and behavioral health data for all health home members. Treatment plan and related data metrics will be incorporated into this platform.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

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<th>Description</th>
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<tr>
<td>Certified ACIST Health Home Provider</td>
<td>This HH component can be completed by any ACIST team member as most appropriate for the individual's symptom presentation but will be developed utilizing protocols established and monitored by the team leader.</td>
</tr>
</tbody>
</table>
Scheduling and communicating appointment times, including arranging transportation and support if necessary;
Conducting referrals, facilitating linkages, and following up;
Participating in hospital discharge processes and communicating with members/family enrollees and other providers, including, as applicable, DSHP Plus LTSS case management and service providers.

Health Home services shall not duplicate services available to individuals under the Medicaid State Plan. For individuals receiving LTSS, Delaware will institute strategies through the comprehensive planning process to ensure no duplication of comparable benefits.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

ACIST Health Home providers will utilize electronic health records as required by the State of Delaware, enabling the integration of key health, social, and behavioral health data for all health home members.

Scope of service

The service can be provided by the following provider types
- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dietitians
- Nutritionists
- Other (specify)

Scope of service

The service can be provided by the following provider types
- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dietitians
- Nutritionists
- Other (specify)
For those persons with a representative payee, the team will work with the person served and the representative payee to ensure that the individual's financial needs are met, coordinated and

Education, support, and consultation to individuals' families and other major supports

Employment/supported employment will be encouraged and supported for all individuals being supported by the team

Social skills training and rehabilitation necessary for functioning in a work, educational, volunteer, leisure or other community environment.

and renter's rights and responsibilities to the degree the individual is able to participate. In addition, Individual and Family Support Services may include:

Improving their adherence to treatment and medication management. Individual and family support services also involve identifying supports needed for the member and family/support persons

d) Assessing the patient's risk status for readmission to the hospital or other failure to obtain community-based care;

e) Arranging for follow-up management, as applicable and

f) Planning appropriate care/place to stay post-discharge, including linkages to temporary or permanent housing and arranging transportation as needed.

The member and family/support persons may be assisted through e-mails, texts, phone calls, letters, and in-person. Skills training in activities related to self-care and daily life management

At a minimum, the HH will:

• use hospitalization or emergency department episodes to locate and engage members in need of HH services;

• perform the required continuity of care coordination between inpatient and outpatient care, including establishment or reestablishment of community resources and necessary follow-up visits; and

• engage in proactive steps to avoid readmission (including work with the individual and his/her family and analysis of antecedent activities to interrupt patterns of inpatient utilization)

HHs will have a clear protocol for responding to alerts from hospitals or any other inpatient facility to facilitate collaboration in treatment, discharge, and safe transitional care. Services as part of beneficiary contacts during transitions include but are not limited to:

a) Assisting in the development of discharge strategies;

b) Performing medication reconciliation;

c) Ensuring that follow-up appointments are scheduled and coordinated;

d) Assessing the patient's risk status for readmission to the hospital or other failure to obtain community-based care;

e) Arranging for follow-up care management, as applicable and

f) Planning appropriate care/place to stay post-discharge, including linkages to temporary or permanent housing and arranging transportation as needed.

Health Home services shall not duplicate services available to individuals under the Medicaid State Plan. For individuals receiving LTSS, Delaware will institute strategies through the comprehensive planning process to ensure no duplication of comparable benefits.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

ACIST Health Home providers will utilize electronic health records as required by the State of Delaware, enabling the integration of key health, social, and behavioral health data for all health home members.

The service can be provided by the following provider types

Individual and Family Support (which includes authorized representatives)

Definition

Individual and family support services include activities that ensure that the HH member and family/support persons are knowledgeable about the member's conditions with the overall goal of improving their adherence to treatment and medication management. Individual and family support services also involve identifying supports needed for the member and family/support persons to manage the member's condition and assisting them to access these support services.

The member and family/support persons may be assisted through e-mails, texts, phone calls, letters, and in-person. Skills training in activities related to self-care and daily life management including utilization of public transportation, maintenance of living environment, money management, meal preparation, locating and maintaining a home, skills in landlord/tenant negotiations and renter's rights and responsibilities to the degree the individual is able to participate. In addition, Individual and Family Support Services may include:

a) Social skills training and rehabilitation necessary for functioning in a work, educational, volunteer, leisure or other community environment.

b) Employment/supported employment will be encouraged and supported for all individuals being supported by the team

c) Education, support, and consultation to individuals' families and other major supports

d) For those persons with a representative payee, the team will work with the person served and the representative payee to ensure that the individual's financial needs are met, coordinated and
Health Home services shall not duplicate services available to individuals under the Medicaid State Plan. For individuals receiving LTSS, Delaware will institute strategies through the comprehensive planning process to ensure no duplication of comparable benefits.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

ACIST Health Home providers will utilize electronic health records as required by the State of Delaware, enabling the integration of key health, social, and behavioral health data for all health home members.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

Referral to Community and Social Support Services

Definition

Referral to community and social support services involves determining appropriate services to meet the needs of members, identifying and referring members to available community resources, and following up with members. Referral and linkage or direct assistance to ensure that individuals obtain the basic necessities of daily life including medical, social, financial supports. Communication and information will meet health literacy standards, trauma informed care standards, and be culturally appropriate.

Community and social support services may include, but are not limited to:
- Identifying the member’s community and social support needs.
- Identifying resources and eligibility criteria for housing, food security and nutrition, employment counseling, child care, community-based LTSS, school and faith-based services, and disability services, as needed and desired by the member, and referring members as appropriate.
- Identifying or developing a comprehensive individually-tailored resource guide for the member.
- Actively managing appropriate referrals to the needed resources, access to care, and engagement with other community and social supports.
- Following up with the member to ensure needed services are obtained.
- Coordinating services and follow-up post engagement.
- Checking with member routinely to ensure they are accessing the social services they require.

Health Home services shall not duplicate services available to individuals under the Medicaid State Plan. For individuals receiving LTSS, Delaware will institute strategies through the comprehensive planning process to ensure no duplication of comparable benefits.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

ACIST Health Home providers will utilize electronic health records as required by the State of Delaware, enabling the integration of key health, social, and behavioral health data for all health home members.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
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<th>Description</th>
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</table>
| Certified ACIST Health Home Provider | Certified ACIST Health Home Provider  
Bachelor's level care manager within the team followed by his/her direct supervisor. |
Health Homes Services

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter.

Referral source will complete a Brief Screen for Eligibility followed by an application for ACIST Services. Brief Screen will be reviewed by Division of Developmental Disabilities Services Crisis Care Coordinator for eligibility. Referral will be directed to equivalent DSAMH Services when appropriate and/or individual does not meet ACIST Criteria. ACIST Application, eligibility, insurance coverage, consent for treatment, consent to release information and assurances will be reviewed by Developmental Disabilities Services Crisis Care Coordinator for completion and forwarded to chosen Health Home Provider.

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Health Homes Monitoring, Quality Measurement and Evaluation

**Monitoring**

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates.

Delaware will calculate and monitor cost savings through a number of mechanisms. For individuals with an established Medicaid claim history, cost savings data will be calculated by comparing current year with historical costs for individuals. For individuals without established claims history, the state will determine a projected service utilization trajectory using data from individuals with similar presentation and symptoms to ascertain the cost avoidance achieved through the health home intervention. In addition, Delaware will include an analysis of individual outcomes to demonstrate the value provided through the health homes (employment, housing stability, etc).

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

The State will require that participating health homes providers use an operational Electronic Health Record (EHR) system to support the delivery of health home services. This EHR will be prescribed by the state and will include individual health statistics, service utilization, risk assessments, and comprehensive person-centered plan information. The EHR enables data sharing (with appropriate permissions) among the individual, the providers supporting him/her, and the state to ensure a comprehensive, whole-person record of support. The system will include critical health information including pharmacology to ensure complete integration of physical health, behavioral health and long-term services and supports. The system will also include information on what is important to the individual in addition to what is important for the individual, ensuring that supports and services are undertaken with an understanding of personal preferences.

This system will enable real-time access to data to inform linkages to needed social supports and other determinants of health. It will foster and further seamless transitions when individuals experience inpatient encounters, and will ensure full team access to all necessary information.
Quality Measurement and Evaluation

- The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state.
- The state provides assurance that it will identify measurable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.
- The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.
- The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: DELAWARE

CASE MANAGEMENT SERVICES

A. Target Group:

B. Areas of State in which services will be provided:

☐ Entire State.

☐ Only in the following geographic areas (authority of section 1915(g)(1) of Act is invoked to provide services less than Statewide):

C. Comparability of Services

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☐ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

E. Qualification of Providers:


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D. Definition of Services:

Case management of high risk pregnant women must include at least the following components:

**NUTRITION**
- nutrition assessment and counseling
- WIC – Food Stamps application assistance
- infant feeding, breast feeding, child care information classes

**SOCIAL WORKER**
- counseling, access to needed services to resolve problems such as with education, creditors, mental health;
- referrals to child watch, child abuse help groups; parenting skills
- long-term planning for self sufficiency through employment/training/education/referrals following delivery;
- substance abuse counseling;
- stop smoking clinic referral and assistance in attending;
- referral to genetic screening and counseling services.

**NURSING**
- weekly/monthly health assessment by RN with report of suspected problem to attending physician;
- Education on appropriate pregnancy topics; childbirth, newborn care (anticipating guidance).

**OUTREACH**
- contact client prior to pre-natal visit (phone/home visit);
- arrange transportation and babysitting, especially to assure all medical appointments are kept;
- accompany client to meetings, appointments as necessary;
- follow up to reschedule missed appointments;
- act as translator;
- facilitate implementation of goals of the care plan as directed by professional staff.

**POST PARTUM**
Continue services and resolve problems in 60 day post partum period including pregnancy prevention, infant care, assisting clients to plan for self sufficiency through referral to appropriate employment and training counseling services.
E. Qualification of Providers:

Qualified providers of case management services for high risk pregnant women will be those that can provide all of the service components described in item D on page 1a, and who have staff or contractual arrangements to make up a case management team as defined below:

**Qualifications of Case Management Team Members**

**NUTRITION**
shall be a Registered Dietitian of Nutritionist.

**SOCIAL WORKER**
shall be an employee with a Bachelors of Arts or Bachelors of Science degree in social work, counseling or related social services field.

**NURSING**
shall be a Registered Nurse licensed to practice in the State of Delaware.

**OUTREACH**
these members shall be experienced para-professionals operating under the supervision of the professional staff.

**CLERICAL/SUPPORT**
contractor shall have adequate clerical support staff to track, file, type, etc. all necessary documentation required to the case management team.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: DELAWARE

F. The State assures that the provision of case management services will not restrict an individual’s free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: DELAWARE

I. Eligibility
The State determines eligibility for PACE enrollees under rules applying to community groups.

A. The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. Spousal impoverishment eligibility rules will apply. The applicable groups are:

* Individuals receiving services under this program are eligible under the following eligibility groups:

  - A Special Income Level equal to 250% of the SSI Federal Benefit (FBR) (42 CFR 435.236)

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State’s Medicaid plan.)

B. The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II – Compliance and State Monitoring of the PACE Program.

C. The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State’s approved HCBS waiver(s).
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: DELAWARE

Regular Post Eligibility

1. ___ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

   (a). Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:
   (A.) Individual (check one)
      1. ___ The following standard included under the State plan (check one):
         (a) _____ SSI
         (b) _____ Medically Needy
         (c) _____ The special income level for the institutionalized
         (d)_____ Percent of the Federal Poverty Level: _________%
         (e)_____ Other (specify): __________________________
     2. ___ The following dollar amount: $________
        Note: If this amount changes, this item will be revised.
     3. ___ The following formula is used to determine the needs allowance:

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 1 and 3.

B.) Spouse only (check one)
   1. ___ SSI Standard
   2. ___ Optional State Supplement Standard
   3. ___ Medically Needy Income Standard
   4. ___ The following dollar amount: $________
      Note: If this amount changes, this item will be revised.
   5. ___ The following percentage of the following standard that is greater than the standards above: ___ % of ___ standard.
   6. ___ The amount is determined using the following formula:
   7. ___ Not applicable (N/A)
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: DELAWARE

Regular Post Eligibility Continued

(C) Family (check one):
1. _____ AFDC need standard
2. _____ Medically needy income standard

The amount specified below 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 of the medically needy income standard established under 435.811 for a family of the same size.

3. _____ The following dollar amount: $________
   Note: If this amount changes, this item will be revised.
4. _____ The following percentage of the following standard that is not greater than the standards above: _____ % of _____ standard.
5. _____ The amount is determined using the following formula: ___________________________________________
6. _____ Other: ____________________________________
7. _____ Not applicable (N/A).

(2). Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

2. _____ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducing the following amounts from the PACE enrollee’s income.

(a) 42 CFR 435.735 – State using more restrictive requirements then SSI.

1. Allowances for the needs of the:
   A. Individual (check one)
      1. The following standard included under the State plan (check one):
         (a) _____ SSI
         (b) _____ Medically Needy
         (c) _____ The special income level for the institutionalized
         (d) _____ Percent of the Federal Poverty Level: ___%
         (e) _____ Other (specify): __________________________

TN No. SPA# #11-010 Approval Date February 28, 2012
Supersedes
TN No. # NEW Effective Date October 1, 2011
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: **DELAWARE**

2. The following dollar amount: $ ___
   Note: If this amount changes, this item will be revised.
3. The following formula is used to determine the needs allowance:

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):
1. The following standard under 42 CFR 435.121:

2. The Medically needy income standard

3. The following dollar amount: $ ___
   Note: If this amount changes, this item will be revised.
4. The following percentage of the following standard that is not greater than the standards above: ___% of ___ standard.
5. The amount is determined using the following formula:

6. Not applicable (N/A)

(C.) Family (check one):
1. AFDC need standard
2. Medically needy income standard

The amount specified below 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 435.811 for a family of the same size.

3. The following dollar amount: $ ___
   Note: If this amount changes, this item will be revised.
4. The following percentage of the following standard that is not greater than the standards above: ___% of ___ standard.
5. The amount is determined using the following formula:

6. Other
7. Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: DELAWARE

Spousal Post Eligibility

3. State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:
   1. Individual (check one)
      (A)_____ The following standard included under the State plan

      (checkone):
      1. ______SSI
      2. ______Medically Needy
      3. ______The special income level for the institutionalized
      4. ______Percent of the Federal Poverty Level: _______%
      5. ______Other (specify): ____________________________

      (B)_____ The following dollar amount: $.__________
      Note: If this amount changes, this item will be revised.

      (C)_____ The following formula is used to determine the needs
      allowance:

      _______________________________________________________

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

________________________________________________________________
________________________________________________________________

---

TN No. SPA# #11-010
Supersedes
TN No. # NEW
Approval Date February 28, 2012
Effective Date October 1, 2011
II. Rates and Payments

A. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1. **X** Rates are set at a percent of fee-for-service cost
2. ____ Experience-based (contractors/State’s cost experience or encounter date) (please describe)
3. ____ Adjusted Community Rate (please described)
4. ____ Other (please describe)

*See Pages 7 and 8 for description of rate setting methodology*

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

Mercer Government Human Services Consulting
2325 East Camelback Road, Suite 600
Phoenix, Arizona 85016
Attention: Frederick P. Gibison, Jr.
1.602. 522. 6526

C. The State will submit all capitated rates to the CMS Regional Office for prior approval.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: **DELAWARE**

**CAPITATED RATE METHODOLOGY**

**Base Data Source and Analysis**

The PACE rates are based on the Upper Payment Limit (UPL) methodology. The historical fee for service target population data is extracted for claims and eligibility for more than one year. PACE eligibility populations used to develop the PACE UPLs are individuals enrolled in home and community based waivers (HCBS) and individuals in nursing facilities. These two populations serve as the basis upon which the PACE UPLs are developed.

Claims and eligibility data are gathered for both Medicaid-only individuals receiving the aforementioned services and also those individuals fully dually eligible for Medicaid and Medicare Parts A/B/D. Historical FFS data is compiled by date of service for the applicable year from the State's MMIS and eligibility system. Data for clients in the aforementioned two groups who are not eligible to enroll in PACE (e.g., those under age 55) are excluded from the database. The PACE UPLs include payment for all covered Medicaid services as well as Medicare coinsurance and deductible payments for full dual eligible clients. The final UPLs are developed for two rating groups: Dual Eligible - Age 55+ and Medicaid-only Age 55+.

The FFS data used in the analysis is reviewed for reasonableness to be (or as necessary adjusted to be) appropriate for UPL development as described in the most current version of the CMS PACE checklist.

- Claims expenditures for the PACE-equivalent population include Medicaid paid amounts increased by applicable patient liability and co-payments paid by recipients.
- Data for partial dual eligible populations were specifically excluded from the analysis, as they are not entitled to Medicaid services.
- Claims for services that are not covered services under PACE are not included.

**Adjustments to Develop the UPL**

The prospective UPL is subject to the following adjustments;

- Base Data Adjustments: The historical FFS base data are adjusted to comply with the requirements in the PACE UPL checklist and to ensure that the UPLs reflect what otherwise would have been paid under the State plan if participants were not enrolled in PACE (e.g., FFS pharmacy rebates, completion factors, copayments and patient liability).
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CAPITATED RATE METHODOLOGY (cont’d)

- Prospective Trend: Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor is necessary to estimate the cost of health care services in a defined contract period. As part of the UPL development for the PACE program, annual per-member-per-month (PMPM) trend rates by consolidated COS are developed. The base data is trended forward to the midpoint of the contract period.
- Programmatic Changes: Programmatic changes recognize the impact of changes to benefits, eligibility or State reimbursement that take place between the base period and the projection period.
- State Administrative Costs: An estimate of the State’s FFS administrative costs is included in the UPL development process.

PACE Capitation Rates

The State will ensure compliance with 42 CFR 460.182(b) by assuring that the PACE capitation rates will be a fixed percentage, of less than 100 percent, of the respective PACE UPL amounts. This percentage will consider differences between the FFS population from which the PACE UPLs were built and the expected enrollment in the PACE plans including relative acuity and the impact of better care management/care coordination.
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STATE/TERRITORY: DELAWARE

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: DELAWARE

TARGET CASE MANAGEMENT SERVICES FOR

Individuals with Intellectual and Developmental Disabilities Meeting Delaware DDDS Eligibility Criteria Living In their Own Home or their Family’s Home

A. Target Group - Services shall be provided to participants who (42 CFR §441.18(a)(8)(i) and §441.18(a)(9)):

1. Meet the eligibility requirements set forth in 16 DE Admin. Code 2100 Division of Developmental Disabilities Services (DDDS) Eligibility Criteria which requires a diagnosis of an intellectual developmental disability (including brain injury), autism spectrum disorder or Prader Willi Syndrome with functional limitations; and,

2. Reside in their own home or their family home and do not receive residential habilitation services.

X Target group includes individuals transitioning to a community setting. Case management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between the ages of 21 and 64 who are served in Institutions for Mental Disease (IMD) or individuals who are inmates of public institutions (State Medicaid Directors Letter 072500b, July 25, 2000).

B. Areas of State in which services will be provided (§1915(g)(1)):

X Entire State

_ Only in the following geographic areas: [Specify areas]

C. Comparability of Services (§1902(a)(10)(B) and §1915(g)(1))

_ Services are provided in accordance with §1902(a)(10)(B) of the Act

X Services are not comparable in amount, duration, and scope (§1915(g)(1))

D. Definition of Services (42 CFR §440.169)

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Targeted Case Management will be performed by individuals called Community Navigators hereafter and includes the following assistance:

1. Comprehensive assessment and periodic reassessment of individual needs, to assist the individual and family to plot a trajectory toward an inclusive, quality, community life. This may include the determination of need for any medical, educational, social or other services. These assessment activities include functions necessary to inform the development of the person-centered plan:

   i) Obtaining client histories and other information necessary for evaluating and/or reevaluating and recommending community based supports and services that may address individual or family needs;
D. Definition of Services (42 CFR §440.169) Continued

1. Comprehensive and Periodic Assessments Continued
   i) Identifying the individual's and/or family's support needs and providing assistance and
      reminders related to completing needed documentation for clinical and financial eligibility for
      assistance programs;
   ii) Gathering information from sources such as family members, medical providers, social workers,
       and educators (if necessary), to form a complete assessment of the eligible individual; and
   iii) Providing necessary education and information to the individual and his/her family to provide
       necessary support to assist them in developing a vision for their life, and to gain understanding
       of transitions that occur through the life course.

   The Community Navigator collects information to inform the planning process and/or directly
   conducts an assessment of an individual's needs, both as targeted case management services begin,
   and at least annually thereafter or more frequently at the request of the individual.

2. Development (and periodic revision) of a person-centered plan in accordance with 42 CFR
   §441.301(c)(1) through 42 CFR §441.301(c)(4). This activity may be conducted through direct and
   collateral contacts. The plan must reflect what is important to the individual to lead the life they
   want to lead. The plan must also identify and reflect the services and supports that are important
   for and to the individual to reach specified goals, to achieve desired outcomes and to meet needs
   identified through an assessment of functional need. The plan must also reflect the individual’s
   preferences for the delivery of such services and supports. Individuals and families may focus on
   their current situation and stage of life but may also find it helpful to look ahead to start thinking
   about what they can do or learn now that will help build an inclusive productive life in the future.

   The Community Navigator:
   i) Uses a person-centered planning approach and a team process to discover what it takes to live
      the life the individual wants to live;
   ii) Uses a person-centered planning approach and a team process to develop the individual’s
       person-centered plan to meet the individual’s needs [and achieve the individual’s goals] in the
       most integrated manner possible;
   iii) Provides support to the individual to ensure that the process is driven by the individual to the
       maximum extent possible and includes people chosen by the individual, with the individual at
       the center of the process;
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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TARGET CASE MANAGEMENT SERVICES FOR

Individuals with Intellectual and Developmental Disabilities Meeting Delaware DDDS Eligibility Criteria Living In their Own Home or their Family’s Home

D. Definition of Services (42 CFR §440.169) Continued

2. Person Centered Plan, Community Navigator Continued
   iv) Develops and updates the person-centered plan of care based upon the individual’s needs and person-centered planning process annually, or more frequently, as needed;
   v) Assists the person to select qualified providers who can best meet their needs;
   vi) Ensures that the plan identifies risk factors and includes plans to mitigate them;
   vii) Facilitates transition for new waiver enrollees moving from their family home to a waiver residence;
   viii) Facilitates seamless transitions between providers, services or settings for the maximum benefit of the individual;
   ix) Updates the person-centered plan of care annually or more frequently, if needed, as the individual’s needs change; and
   x) Obtains necessary consents.

3. Information, referral, facilitating access and related activities (such as assisting individuals in scheduling appointments) to help the eligible individual obtain needed services including activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

The Community Navigator:
   i) Assists individuals and families in gaining information and establishing linkages with peers and/or professionals who can be key informants in supporting individuals with disabilities throughout the life course;
   ii) Assists the individual and the individual’s person-centered planning team in identifying and choosing resources and strategies that aim to promote the development, education, interests, and personal well-being of a person and that enhances individual and family functioning;
   iii) Explores coverage of services, as appropriate, to address individuals’ needs through a full array of sources, including services provided under the State Plan, Medicare, and/or private insurance or other community resources;
   iv) Collaborates and coordinates with other individuals and/or entities essential in supporting the individual, such as MCO representatives, vocational rehabilitation and education coordinators to ensure seamless coordination among needed support services and to ensure that the individual is receiving services as appropriate from other sources.
D. Definition of Services (42 CFR §440.169) Continued

3. Information, referral, facilitating access and related activities, Community Navigator Continued
   v) Coordinates with providers and potential providers to ensure seamless service access and delivery.
   vi) Facilitates access to financial assistance, e.g. Social Security benefits, SNAP, subsidized housing, etc.
   vii) Facilitates continued enrollment in the DDDS HCBS Waiver by gathering or completing necessary documentation.
   viii) Assists individuals in transitioning to and from the Diamond State Health Plan Plus Medicaid LTSS benefit.
   ix) Assists an individual to access legal services.
   x) May assist an individual to obtain transportation to appointments and other activities.
   xi) Informs and assists an individual or his or her family with surrogate decision making and assistance options, including supported decision-making agreements, powers of attorney, and guardianship.
   xii) Facilitates referral to a nursing facility when appropriate and when other available options have been fully considered and exhausted.
   xiii) Participates in transition planning for an individual’s discharge from a nursing facility or hospital within six months of the planned discharge date.
   xiv) Provides advocacy on behalf of individuals to ensure receipt of services as indicated in their person-centered plan.
   xv) Empowers individuals and families to be their own advocates
   xvi) Provides individuals with information regarding their rights, including related to due process and fair hearings, and providing support to individuals as they exercise those rights.

4. Monitoring and follow-up activities and contacts are provided as necessary to ensure the person-centered plan is implemented and addresses the eligible individual’s needs and the individual and individual’s family’s vision for the future. Monitoring ensures that:
   i) Supports and linkages are provided as indicated in the individual’s person-centered plan;
   ii) Supports and services in the person-centered plan are adequate; and
   iii) Changes in the needs or status of the individual are reflected in the person-centered plan.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: DELAWARE

TARGET CASE MANAGEMENT SERVICES FOR

Individuals with Intellectual and Developmental Disabilities Meeting Delaware DDDS Eligibility Criteria Living In their Own Home or their Family’s Home

D. Definition of Services (42 CFR §440.169) Continued

4. Monitoring and follow-up activities Continued

Monitoring and follow up activities include making necessary adjustments in the person-centered plan and service arrangements with providers as follows:

i) Monitoring through regular monthly contacts that can include face-to-face, telephone or email contacts with the recipient or on behalf of the recipient, taking into account the communication preferences of the individual/guardian;

ii) Monitoring of the health and welfare of the individual and incorporating the results into revisions to individual service plans as necessary to ensure that the individual can meet his or her goals;

iii) Activities and contacts necessary to ensure that the individual service plan is effectively implemented and adequately addresses the needs of the eligible individual;

iv) Responding to and assessing emergency situations and incidents and ensuring that appropriate actions are taken to protect the health, welfare and safety of the individual;

v) Reviewing provider documentation of service provision, as appropriate, and monitoring individual progress on goals identified in the person-centered plan, and initiating contact when services are not achieving desired outcomes;

vi) Participation in investigations of reportable incidents, as appropriate and integrating prevention strategies into revisions to individual service plans as necessary to remediate individual and systemic issues;

vii) Ensuring that linkages are made and services are provided in accordance with the individual service plan;

viii) Activities and contacts that are necessary to ensure that individuals and their families (as appropriate) receive appropriate notification and communication related to unusual incidents and major unusual incidents; and

ix) Soliciting input from the individual and/or family related to information and supports that would be or have been most helpful.

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case manager to changes in the eligible individual's needs. 42 CFR §440.169(e).
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STATE: DELAWARE

TARGET CASE MANAGEMENT SERVICES FOR

Individuals with Intellectual and Developmental Disabilities Meeting Delaware DDDS Eligibility Criteria Living In their Own Home or their Family’s Home

Provider Qualifications (42 CFR §441.18(a)(8)(v) and 42 CFR §441.18(b))

Qualified providers are entities under contract with the State of Delaware with requisite expertise in supporting individuals with intellectual and developmental disabilities and their families.

Specifically, the providers will comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. Individuals providing this service must:

1. Have an associate’s degree or higher in behavioral, social sciences, or a related field OR experience in health or human services support, which includes interviewing individuals and assessing personal, health, employment, social, or financial needs in accordance with program requirements;
2. Have demonstrated experience and competency in supporting families;
3. Complete Department-required training, including training on the participant’s service plan and the participant’s unique and/or disability-specific needs, which may include but is not limited to: communication, mobility and behavioral support needs; and
4. Comport with other requirements as required by the Department.

Freedom of Choice (42 CFR §441.18(a)(1))

The State assures that the provision of case management services will not restrict an individual’s free choice of providers in violation of §1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in the plan; and
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR §441.18(b))

X Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services. Providers must be selected through a competitive procurement process by the Delaware Division of Developmental Disabilities Services (DDDS), in accordance with the 1915(b)(4) waiver. This process will ensure that every jurisdiction in the State will be able to receive high-quality, comprehensive case management services to eligible individuals.

The providers of services under this authority are limited to designated contracted entities and individuals with necessary knowledge, skills and abilities to effectively provide Targeted Case Management Services to individuals within the target group. The state ensures that all individuals within the target group will receive unfettered access to these services.
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TARGET CASE MANAGEMENT SERVICES FOR

Individuals with Intellectual and Developmental Disabilities Meeting Delaware DDDS Eligibility Criteria Living In their Own Home or their Family’s Home

Access to Services (42 CFR §441.18(a)(2), 42 CFR §441.18(a)(3), 42 CFR §441.18(a)(6):

The state assures the following:

1. Case management (including targeted case management) services will not be used to restrict an individual’s access to other services under the plan;
2. Individuals will not be compelled to receive case management services, condition receipt of services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
3. Providers of case management services do not exercise the agency’s authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR §441.18(a)(4):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other programs authorities for the same purpose.

Case Records (42 CFR §441.18(a)(7))

Providers maintain case records that document for all individuals receiving case management as follows:

(i) The name of the individual;
(ii) The dates of the case management services;
(iii) The name of the provider agency (if relevant) and the person providing the case management service;
(iv) The nature, content, units of case management services received and whether goals specified in the care plan have been achieved;
(v) Whether the individual has declined services in the care plan;
(vi) The need for, and occurrences of, coordination with other case managers;
(vii) A timeline for obtaining needed services;
(viii) A timeline for reevaluation of the plan.
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TARGET CASE MANAGEMENT SERVICES FOR

Individuals with Intellectual and Developmental Disabilities Meeting Delaware DDDS Eligibility Criteria Living In their Own Home or their Family’s Home

Limitations

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid services (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placements arrangements (42 CFR §441.18(c)).

FFP is only available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§1902(a)(25) and §1905(c)).

Coverage Exclusions: None
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: DELAWARE

TARGET CASE MANAGEMENT SERVICES FOR

Individuals with Intellectual and Developmental Disabilities Approved for Funding through the Delaware DDDS HCBS Waiver Program DE 0009 Who Are Authorized to Receive Residential Habilitation

A. Target Group - Services shall be provided to participants who (42 CFR §441.18(a)(8)(i) and §441.18(a)(9)):

1. Meet the eligibility requirements set forth in 16 DE Admin. Code 2100 Division of Developmental Disabilities Services (DDDS) Eligibility Criteria which requires a diagnosis of an intellectual developmental disability (including brain injury), autism spectrum disorder or Prader Willi Syndrome with functional limitations; and,
2. Have been approved to receive residential habilitation under the Delaware HCBS waiver program DE 0009 administered by the Delaware Division of Developmental Disabilities Services (DDDS) authorized under Section §1915(c) of the Social Security Act.

X Target group includes individuals transitioning to a community licensed and/or certified setting. Case management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between the ages of 21 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions (State Medicaid Directors Letter 072500b, July 25, 2000) or individuals receiving services and supports while living in their own or family home.

B. Areas of State in which services will be provided(§1915(g)(1)):

X Entire State
_ Only in the following geographic areas: [Specify areas]

C. Comparability of Services (§1902(a)(10)(B) and§ 1915(g)(1))

_ Services are provided in accordance with §1902(a)(10)(B) of the Act
X Services are not comparable in amount, duration, and scope (§1915(g)(1))

D. Definition of Services (42 CFR §440.169)

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Targeted Case Management will be performed by individuals called Support Coordinators hereafter and includes the following assistance:

1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include functions necessary to inform the development of the person-centered plan:
D. Definition of Services (42 CFR §440.169) Continued

1. Comprehensive and Periodic Assessments Continued

   i) Obtaining client histories and other information necessary for evaluating and/or reevaluating and recommending determination of the individual’s level of care;
   
   ii) Identifying the individual’s support needs and providing assistance and reminders related to completing needed documentation for clinical and financial eligibility;
   
   iii) Gathering information from sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
   
   iv) Providing necessary education and information to the individual and the individual’s family to provide necessary familiarity with the program, requirements, rights and responsibilities.

The Support Coordinator collects information to inform the plan and/or directly conducts an assessment of an individual’s needs for services prior to waiver enrollment and at least annually thereafter or more frequently at the request of the individual or as changes in the circumstances of the person warrant. This is the frequency of review that is specified in the approved DDDS HCBS waiver.

2. Development (and periodic revision) of a specific person-centered plan in accordance with 42 CFR §441.301(c)(1) through 42 CFR §441.301(c)(4). This activity may be conducted through direct and collateral contacts. The plan must reflect what is important to the individual to lead the life they want to lead. The plan must also reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports.

The Support Coordinator:

   i) Uses a person-centered planning approach and a team process to develop the individual’s person-centered plan to meet the individual’s needs and achieve the individual’s goals in the most integrated setting and manner possible;
   
   ii) Provides support to the individual to ensure that the process is driven by the individual to the maximum extent possible and includes people chosen by the individual, with the individual at the center of the process;
   
   iii) Assists the person to select qualified providers who can best meet their needs;
   
   iv) Ensures that the plan identifies risk factors and includes plans to mitigate them;
   
   v) Facilitates transition for new waiver enrollees moving from their family home to a waiver residence;
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STATE: DELAWARE

TARGET CASE MANAGEMENT SERVICES FOR

Individuals with Intellectual and Developmental Disabilities Meeting Delaware DDDS Eligibility Criteria Living In their Own Home or their Family’s Home

D. Definition of Services (42 CFR §440.169) Continued

2. Person Centered Plan, Support Coordinator Continued

   vi) Facilitates seamless transitions between providers, services or settings for the maximum benefit of the individual;
   vii) Updates the person-centered plan annually or more frequently, if needed, as the individual’s needs change;
   viii) Provides individuals with information regarding their rights, including related to due process and fair hearings, and providing support to individuals as they exercise those rights; and
   ix) Obtains necessary consents.

3. Information, referral, facilitating access and related activities to help the eligible individual obtain needed services including activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

The Support Coordinator:

   i) Assists individuals and families in gaining information and establishing linkages with peers, professionals or organizations who can be key informants in supporting individuals with disabilities throughout the life course;
   ii) Explores coverage of services to address individuals’ needs through a full array of sources, including services provided under the State Plan, Medicare, and/or private insurance or other community resources;
   iii) Collaborates and coordinates with other individuals and/or entities essential in the delivery of services for the individual, such as MCO representatives, vocational rehabilitation and education coordinators to ensure seamless coordination among needed support services and to ensure that the individual is receiving services as appropriate from other sources;
   iv) Coordinates with providers and potential providers to ensure seamless service access and delivery;
   v) Facilitates access to financial assistance, e.g. Social Security benefits, SNAP, subsidized housing, etc.;
   vi) Facilitates continued enrollment in the DDDS HCBS Waiver by gathering or completing necessary documentation;
   vii) Assists individuals in transitioning to and from the Diamond State Health Plan Plus Medicaid LTSS benefit;
   viii) Assists an individual to access legal services;
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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TARGET CASE MANAGEMENT SERVICES FOR

Individuals with Intellectual and Developmental Disabilities Meeting Delaware DDDS Eligibility Criteria Living In their Own Home or their Family’s Home

D. Definition of Services (42 CFR §440.169) Continued

3. Information, referral, facilitating access and related activities, Support Coordinator Continued

   i) May assist an individual to obtain transportation to appointments and other activities.
   ii) Informs and assists an individual or his or her family with surrogate decision making and assistance options, including supported decision-making agreements, powers of attorney, and guardianship.
   iii) Facilitates referral to a nursing facility when appropriate and when other available options have been fully considered and exhausted.
   iv) Participates in transition planning for an individual’s discharge from a nursing facility or hospital within six months of the planned discharge date.

4. Monitoring and follow-up activities and contacts are provided as necessary to ensure the person-centered plan is implemented and addresses the eligible individual’s needs and the individual and individual’s family’s vision for the future. Monitoring ensures that: Monitoring and follow-up activities that include activities and contacts that are necessary to ensure the person-centered plan is implemented and adequately addresses the eligible individual’s needs, and which may be with the individual, family members, service providers, or other entities or individuals. The contacts are conducted as frequently as necessary, in accordance with a minimum frequency as specified in the approved HCBS waiver application, to determine whether the following conditions are met:

   i) Services are being furnished in accordance with the individual's person-centered plan;
   ii) Services in the person-centered plan are adequate; and
   iii) Changes in the needs or status of the individual are reflected in the person-centered plan.

Monitoring and follow up activities include making necessary adjustments in the person-centered plan and service arrangements with providers, including:

   i) Monitoring of the health and welfare of the individual through monthly contacts that can include face-to-face, telephone or email contacts with the recipient or on behalf of the recipient, taking into account the communication preferences of the individual/guardian and incorporating the results into revisions to individual service plans as necessary to ensure that the individual can meet his or her goals;
   ii) Activities and contacts necessary to ensure that the individual service plan is effectively implemented and adequately addresses the needs of the eligible individual;
   iii) Ensuring that services are provided in accordance with 42 CFR §441.301(c)(4);
   iv) Providing advocacy on behalf of individuals to ensure receipt of services as indicated in their person-centered plan;
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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TARGET CASE MANAGEMENT SERVICES FOR

Individuals with Intellectual and Developmental Disabilities Meeting Delaware DDDS Eligibility Criteria Living In their Own Home or their Family’s Home

D. Definition of Services (42 CFR §440.169) Continued

4. Monitoring and Follow-up Continued

v) Responding to and assessing emergency situations and incidents and ensuring that appropriate actions are taken to protect the health, welfare and safety of the individual;

vi) Participating in planning meetings to address individual crisis needs, discuss options and ensure that an action plan is developed and executed;

vii) Assessing whether the individual’s crisis is being mitigated, and following up when appropriate through contact with the individual and any service providers;

viii) Reviewing provider documentation of service provision and monitoring individual progress on goals identified in the person-centered plan, and initiating contact when services are not achieving desired outcomes;

ix) Participation in investigations of reportable incidents and integrating prevention strategies into revisions to individual service plans as necessary to remediate individual and systemic issues;

x) Ensuring that services are provided in accordance with the individual service plan and individual service plan services are effectively coordinated through communication with service providers;

xi) Activities and contacts that are necessary to ensure those individuals and their families (as appropriate) receive appropriate notification and communication related to unusual incidents and major unusual incidents;

xii) Soliciting input from the individual and/or family, as appropriate, related to their satisfaction with the services;

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual’s needs. 42 CFR §440.169(e)).

Provider Qualifications (42 CFR §441.18(a)(8)(v) and 42 CFR §441.18(b)

The State of Delaware, Division of Developmental Disabilities Services (DDDS) in the Department of Health and Social Services (DHSS) shall be the entity enrolled to provide Targeted Case Management to this target group.

Qualified Support Coordinators shall include state employees determined by DDDS to have the requisite expertise to be able to support individuals with intellectual and developmental disabilities. The Support Coordinator must have knowledge about services to persons with intellectual and developmental disabilities; knowledge of the interdisciplinary approach to person centered planning, skill in facilitating positive group processes, the ability to translate clinical and other assessments and recommendations into program activities and the ability to develop realistic objectives for each service.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: DELAWARE

TARGET CASE MANAGEMENT SERVICES FOR

Individuals with Intellectual and Developmental Disabilities Meeting Delaware DDDS Eligibility Criteria Living In their Own Home or their Family’s Home

Provider Qualifications (42 CFR §441.18(a)(8)(v) and 42 CFR §441.18(b) Continued

Specifically, the Support Coordinators will comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. Individuals providing this service must:

1. Have an associate’s degree or higher in behavioral, social sciences or a related field OR experience in health or human services support, which includes interviewing individuals and assessing personal, health, employment, social, or financial needs in accordance with program requirements.
2. Complete DDDS-required training, including training on the participant’s service plan and the participant’s unique and/or disability-specific needs, which may include but is not limited to: communication, mobility and behavioral support needs.
3. Comport with other requirements as specified by DDDS and DHSS.

Freedom of Choice (42 CFR §441.18(a)(1)

The State assures that the provision of case management services will not restrict an individual’s free choice of providers in violation of §1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in the plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR §441.18(b))

X Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

The providers of services under this authority are limited to designated state staff with necessary knowledge, skills and abilities to effectively provide TCM to individuals within the target group. The state ensures that all individuals within the target group will receive unfettered access to these services.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: DELAWARE

TARGET CASE MANAGEMENT SERVICES FOR

Individuals with Intellectual and Developmental Disabilities Meeting Delaware DDDS Eligibility Criteria Living In their Own Home or their Family’s Home

Access to Services (42 CFR §441.18(a)(2), 42 CFR §441.18(a)(3), 42 CFR §441.18(a)(6):

The state assures the following:

1. Case management (including targeted case management) services will not be used to restrict an individual’s access to other services under the plan.
2. Individuals will not be compelled to receive case management services, condition receipt of services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
3. Providers of case management services do not exercise the agency’s authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR §441.18(a)(4):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other programs authorities for the same purpose.

Case Records (42 CFR §441.18(a)(7))

Providers maintain case records that document for all individuals receiving case management as follows:

1. The name of the individual;
2. The dates of the case management services;
3. The name of the provider agency (if relevant) and the person providing the case management service;
4. The nature, content, units of case management services received and whether goals specified in the care plan have been achieved;
5. Whether the individual has declined services in the care plan;
6. The need for, and occurrences of, coordination with other Support Coordinators;
7. A timeline for obtaining needed services; and
8. A timeline for reevaluation of the plan.

Limitations

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid services (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing...
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: DELAWARE

TARGET CASE MANAGEMENT SERVICES FOR

Individuals with Intellectual and Developmental Disabilities Meeting Delaware DDDS Eligibility Criteria Living In their Own Home or their Family’s Home

Limitations Continued

potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placements arrangements (42 CFR §441.18(c)).

FFP is only available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§1902(a)(25) and §1905(c)).

Coverage Exclusions: None
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: **DELAWARE**

TARGETED CASE MANAGEMENT SERVICES FOR

Children and Youth with Serious Emotional Disturbance, or Co-occurring Mental Health and Substance Use Disorders meeting DPBHS Eligibility Criteria

A. **Target Group:**
   1. Meets the eligibility criteria for services provided by the Division of Prevention and Behavioral Health Services (DPBHS);
   2. Is in a federal eligibility category for Delaware Medical Assistance, which governs the determination of eligibility for Delaware Medical Assistance Program. Services shall be provided to children and adolescents eligible for DPBHS services under 21 years of age diagnosed with a serious emotional disturbance, mental health or substance use disorder, or co-occurring mental health and substance use disorders, according to the current Diagnostic and Statistical Manual of the American Psychiatric Association until they age out of care.
   3. Meets at least two of the following conditions:
      a. Is not linked to behavioral health, health insurance, or medical services;
      b. Lacks basic supports for education, income, shelter, and food;
      c. Needs care coordination services to obtain and maintain community-based treatment and services; or
      d. Is receiving services through DPBHS.
   4. ☒ Target group includes individuals currently living in the community or individuals transitioning to a community setting. Regarding individuals transitioning, targeted case management services will be made available for up to 60 consecutive days of covered stay in an inpatient medical institution (the Medicaid certified facility in which the recipient is currently residing). The target group does not include individuals between ages 22 and 64 who are serviced in institution for Mental Disease or individuals who are inmates of public institutions (State Medicaid Directors Letter (SMDL), July 25, 2000).

B. **Areas of State in which services will be provided:**
   ☒ Entire State.
   ☐ Only in the following geographic areas (authority of section 1915(g)(1) of Act is invoked to provide services less than Statewide:

C. **Comparability of Services:**
   ☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.
   ☒ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

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D. Definition of Services:
Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services, which includes responsibility for locating, coordinating and monitoring appropriate services for an individual. Targeted Case Management includes the following:

1. Comprehensive Assessment and Periodic Reassessment of individual needs, to determine the need for any medical, educational, social, or other services. These assessment activities include:
   - Taking client history;
   - Identifying the individual's needs and strengths and completing related documentation; and
   - Gathering and reviewing documentation/information from other sources such as family members, medical providers, social workers, and educators (if necessary), need to form a complete and comprehensive assessment of the eligible individual.

The Targeted Case Manager will use a child and youth assessment tool designated by the Department or its designee to:
   - Complete the initial assessment and to reassess at a minimum of every 3 months;
   - Record information that may relate to the individual’s mental health, social, familial, educational, cultural, medical, and other areas to evaluate the extent and nature of the individual needs and strengths and assist in the development of the Plan of Care (POC); and
   - Coordinate and facilitate child and family team meetings (e.g., family members, friends, caretakers, providers, educators, and others, as appropriate) that:
     - Identify a team meeting location that is suitable for the child and family’s needs;
     - Convene at least once every 3 months, or more frequently, as clinically necessary or indicated in the Plan of Care.
     - Targeted Case Managers providing certified Wraparound will convene child and family team meetings monthly or more frequently, if needed.

2. Development (and periodic revision) of the Plan of Care based on the information obtained through the initial comprehensive assessment that includes the following:
   - Developed and updated through the Child and Family Team meeting process;
   - Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual;
   - Include a crises plan including the proposed strategies and interventions for preventing and responding to crises and the youth and family’s definition of what constitutes a crises;
   - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
   - Identifies a course of action to respond to the assessed needs of the individual.

3. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, education providers or other programs, services

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and supports that are capable of providing needed services and supports to address identified needs and achieve goals in the care plan).

4. Monitoring and follow-up activities, including activities and contacts as necessary to ensure that the Plan of Care is effectively implemented and adequately addresses the needs of the eligible individual and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including regular (at least one annually) monitoring to:
   • Determine whether the following conditions are met:
     - Services are being furnished in accordance with the individual’s Plan of Care;
     - Services in the care plan are adequate;
     - There are changes in the needs or status of the eligible individual are reflected in the Plan of Care. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
   • Complete a periodic review of the progress that the individual has made on the Plan of Care goals and objective and the appropriateness and effectiveness of services being provided;
   • Provide ongoing follow up on service referrals and monitoring of service provision to ensure that the agreed upon services are provided, meet the individual’s needs and goals, and ensure the quality, quantity, and effectiveness of services are appropriate and in accordance with the Plan of Care; and
   • Revise, continue, or terminate of the Plan of Care, if no longer appropriate.

Targeted case management includes contacts with non-eligible individuals who are directly related to identifying the individual’s needs and care, for the purposes of helping the eligible individual access services, identify needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual’s needs 42 CFR §440.169(e).

E. Qualification of Providers:

A targeted case manager must be employed by DSCYF or a targeted case manager provider agency contracting with DSCYF. A targeted case manager must meet the following criteria:

• Bachelor’s degree or higher in Behavioral or Social Science or related field;
• Certification in the State of Delaware to provide the service, which includes criminal and professional background checks, and completion of state-required training in wraparound philosophy and policies within six months of employment;
• Maintain certification through state approved continuing education/professional development annually;
• Six months experience in case management which includes assessing, planning, developing, implementing, monitoring, and evaluating options and services to meet an individual’s needs;
• Six months experience in making recommendations as part of a client’s service plan, such as, clinical treatment, counseling, or determining eligibility for health or human services/benefits;
• Six month experience in interpreting laws, rules, regulations, standards, policies and procedures; and
Six months experience in narrative report writing.

A highly qualified targeted case manager must be employed by DSCYF or a targeted case manager provider agency contracting with DSCYF. A targeted case manager must meet the following criteria:

- Bachelor's degree, Master's degree preferred, in social work, psychology, counseling, nursing, occupational therapy, vocation rehabilitation, therapeutic recreation, or human resources and two years of experience working with special population groups in a direct care setting or a master's degree in one of the fields listed above;
- Successful completion of the approved wraparound certification training, or be classified as “provisionally certified,” which means one must successfully complete the Wraparound Certification training within nine months of beginning to provide case management;
- Maintain wraparound certification status by attending an approved wraparound recertification training at least once every two years;
- Basic knowledge of behavior management techniques;
- Skill in interviewing to gather data and complete needs and strengths assessment in preparation of narratives/reports, in development of service plans, and in individual and group communication;
- Knowledge of state and federal requirements related to behavioral health; and
- Ability to use community resources.

A Targeted Case Management Provider Agency must have:

- A contract with the State of Delaware with requisite expertise in supporting individuals with serious emotional disturbance, substance use disorder or co-occurring disorder and their families;
- Demonstrated ability to coordinate and link community resources required through at least three years of prior experience;
- At least three years of experience with the targeted group;
- Sufficient staff and/or agreements with community organizations to have the administrative capacity to ensure quality of services in accordance with state and federal requirements;
- A financial management system which provides documentation of services and costs;
- Capacity to document and maintain individual case records in accordance with state and federal requirements;
- Demonstrated ability to assure referrals consistent with section 1902(a)(23), freedom of choice of providers;
- Ability to provide linkage with other case managers to avoid duplication of case management services;
- Ability to determine that the client is included in the target group; and
- Ability to access systems to track the provision of services to the client.
F. Freedom of Choice 42 CFR §441.18(a)(1)

The State assures that the provision of case management services will not restrict an individual’s free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

G. Freedom of Choice Exception §1915(q)(1) and 42 CFR 441.18(b):

Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services: [Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]

The State will limit providers of targeted case management to the Department of Services for Children, Youth and Their Families (DSCYF). DSCYF may sub-contract for this service. This limitation is in compliance with Section 4302.2, paragraph D. of the State Medicaid Manual.

H. Access to Services 42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):

The State assures the following:

a. Targeted case management services will not be used to restrict an individual’s access to other services under the plan;

b. Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition of receipt of other Medicaid services on receipt of targeted case management services; and

c. Providers of case management services do not exercise the agency’s authority to authorize or deny the provision of other services under the plan.

I. Payment 42 CFR 441.18(a)(4)

Payment for targeted case management services under the Medicaid State Plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

J. Case Records 42 CFR 441.18(a)(7)

Providers maintain case records that document the following for all individuals receiving case management:

a. The name of the individual;

b. The dates of targeted case management services;

c. The name of the provider agency (if relevant) and the person providing the case management service;

d. The nature, content, and units of the targeted case management services received and whether goals specified in the Plan of Care have been achieved;

e. Whether the individual has declined in functioning;

f. The need for and occurrences of coordination with other case managers;

g. A timeline for obtaining needed services; and

h. A timeline for reevaluation of the plan.
K. Limitations

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for services as defined in 440.169 when case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302 F)

Case management does not include, and Federal Financial Participation is not available in expenditures for services as defined in 440.169 when case management activities constitute the direct delivery of underlying medical, education, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program, assessment of adoption placements, recruitment or interviewing of potential foster care parents, serving of legal papers, home investigations, providing transportation, administration of foster care subsidies, or arrangements of placements (42 CFR 441.18(c).

FFP is only available for targeted case management services if there are no other third parties liable to pay for such services, including reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with 1903(c) of the Act 1902(a)(25) and 1905(c).

Writing or entering case notes for the member’s case management file and transportation to and from a member or member-related contacts are allowable, but not billable TCM activities.