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.

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TELEMEDICINE-CONTINUED

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 Stata law.

a. Podiatrists' 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

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.

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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 Stale 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.

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

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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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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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 measureable 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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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 on-going 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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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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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.

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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

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.

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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

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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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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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.

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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

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).

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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

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 redevelopment with medical supports 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

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.

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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

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. .

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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

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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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.

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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
3. Chiropractic manipulative treatment.

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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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.

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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 (provider by or under the supervision of a speech pathologist or audiologist).

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

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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 for individuals younger than age 21 are only available as ESPDT services.

Dental services for individuals 21 and older are limited to:

- Diagnostics
- Preventive
- Restorative (Basic)
- Periodontics
- Prosthodontics Repairs
- Oral and maxillofacial Surgery

Limitations on dental services for individuals 21 and older:

- Payments for dental care treatments are subject to a $3 recipient copay
- Annual maximum Adult Dental benefit may not exceed $1,000 per year; except that an additional $1,500 may be authorized on an emergency basis

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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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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 lease every 30 days. OT services can be performed only by a qualified physical therapist or under his or her supervision.

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Qualified occupational therapy practitioners must be licensed per Delaware licensure requirenments 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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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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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.

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LIMITATIONS

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).

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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

(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 involvingindividuals 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 n 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 (Cl) 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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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 (eg., 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.

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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 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 Cl 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.

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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:***

- A Certified Peer on a CI 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 CI 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 CI 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. Cl 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 Cl 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 Cl 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.

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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

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.

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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

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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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 Addiction 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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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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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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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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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.

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.

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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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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 services:

(**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 optimal medial 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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(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

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☒ 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

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☒ 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 medial 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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(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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☒ (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 of 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 of 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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(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 eligibly, coordinates trips, reimburses transportation providers, responds to complaints and employs accountability measures to ensure effective utilization of expenditures. The broker maintains as 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 Information System (MMIS) transmits and eligibility file for all DMAP clients who are eligibility 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.

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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.

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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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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.

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

Citation (s)	Provision (s)
1935(d)(l)	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.

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

Citation (s)		Provision
1927(d)(2) and 1935(d)(2)	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.
	☒	**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

Citation (s)	Provision
1927(d)(2) and 1935(d)(2)	☐ (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) (The Medicaid agency lists specific category of drugs below) (a) Agents when used for anorexia, weight loss, weight gain: Megestrol Acetate, Somatropin, Lipase Inhibitor. Products in these categories require prior authorization. (d) Agents when used for the symptomatic relief cough and colds: Antihistamines, Antitussive, Decongestants, and Expectorants. (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

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

Citation (s)	Provision
1927(d)(2) and 1935(d)(2)	CONTINUED (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 od Providers:

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):_____

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._____0ther
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:

_____

_____

_____

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

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
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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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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/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 intuition 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

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.

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: htt://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

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

STANDARDS FOR THE COVERAGE OF ORGAN AND TISSUE TRANSPLANT SERVICES CONTINUED

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. Transplants 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.

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

Initial Submission Date 10/18/2018

Approval Date 1/15/2019

Effective Date N/A

Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives 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:

a) 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

b) 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

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, support systems and/or significant other in supporting the individual's recovery

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2019	$436050
Second	2020	$436050

Federal Statute / Regulation Citation

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

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

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	**Initial Submission Date**	10/18/2018
Approval Date	1/15/2019	**Effective Date**	N/A
Superseded SPA ID	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

Package ID DE2018MS0002O

SPA ID DE-18-0006

Submission Type Official

Initial Submission Date 10/18/2018

Approval Date 1/15/2019

Effective Date N/A

Superseded SPA ID 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:

- [x] Newspaper Announcement

Name of Paper:	Date of Publication:	Locations covered:
State News	9/3/2018	Kent and Sussex Counties
The News Journal	9/3/2018	New Castle and Kent Counties

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

Date of meeting: 4/19/2018

Time of meeting: 9:00 AM

Location of meeting: DHSS Chapel / 1901 N. DuPont Hwy.; New Castle DE 19720

Communication Method
- Telephonic Capability Used

Public Forum Used
- The Medical Care Advisory Committee that operates in accordance with 42 CFR 431.12

- [ ] Other method

Upload copies of public notices and other documents used

Name	Date Created	
MCAC Minutes_April 2018 Meeting	8/23/2018 3:51 PM EDT	
MCAC Agenda_2018-04-19	8/23/2018 3:51 PM EDT	
284899-1 DHSS- Home Health	9/5/2018 12:06 PM EDT	
Public Notice Newspaper September 3 2018 (002)	9/7/2018 9:05 AM EDT	
DRR Public Notice	10/2/2018 3:23 PM EDT	

1 – 5 of 5

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

Name	Date Created	
Summary of Public Comment	10/2/2018 3:21 PM EDT	

Indicate the key issues raised during the public comment period (optional)

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

Submission - Tribal Input

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

Initial Submission Date 10/18/2018

Approval Date 1/15/2019

Effective Date N/A

Superseded SPA ID N/A

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

Submission - Other Comment

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

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Package ID DE2018MS0002O

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Submission Type Official

Initial Submission Date 10/18/2018

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Effective Date N/A

Superseded SPA ID N/A

SAMHSA Consultation

Name of Health Homes Program

Assertive Community Integration Support Team

Date of consultation
5/17/2018

☑ 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

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	**Initial Submission Date**	10/18/2018
Approval Date	1/15/2019	**Effective Date**	10/1/2018
Superseded SPA ID	new		
	User-Entered		

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 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 multi-disciplinary 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

- [x] The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- [x] The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- [x] 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.
- [x] 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.
- [x] 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.
- [x] The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Attachment 3.1-H

Health Homes Geographic Limitations

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Superseded SPA ID new

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- (•) 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

Attachment 3.1-H

Health Homes Population and Enrollment Criteria

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Superseded SPA ID	new		
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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

Attachment 3.1-H

Health Homes Population and Enrollment Criteria

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Superseded SPA ID new

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Population Criteria

The state elects to offer Health Homes services to individuals with

- [x] Two or more chronic conditions

Specify the conditions included

- [x] Mental Health Condition
- [ ] Substance Use Disorder
- [ ] Asthma
- [ ] Diabetes
- [ ] Heart Disease
- [ ] BMI over 25
- [x] Other (specify)

Name	Description

Name	Description
Severe and Persistent Mental Illness	Severe and Persistent Mental Illness (SPMI) - "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.

Name	Description
Intellectual and Developmental Disability (including autism)	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).

- [ ] One chronic condition and the risk of developing another
- [ ] One serious and persistent mental health condition

Health Homes Population and Enrollment Criteria

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User-Entered

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

Name	Date Created	
ACIST intro letter	4/18/2018 11:07 AM EDT	

Health Homes Providers

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

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Types of Health Homes Providers

- [x] 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)
- [x] Other (Specify)

Provider Type	Description

Provider Type	Description
Certified ACIST Health Home Providers	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 staff 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.

☐ Teams of Health Care Professionals

☐ Health Teams

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 staff 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 staff 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 staff, 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

Attachment 3.1-H

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 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 teams 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.

Name	Date Created	
No items available		

Health Homes Service Delivery Systems

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Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- [x] Fee for Service
- [ ] PCCM
- [ ] Risk Based Managed Care
- [ ] Other Service Delivery System

Health Homes Payment Methodologies

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Payment Methodology

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

- [x] Fee for Service
  - [ ] Individual Rates Per Service
  - [x] Per Member, Per Month Rates
    - [x] 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
      - [x] Other

        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
  - [ ] Comprehensive Methodology Included in the Plan
  - [ ] Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided Not Applicable

- [ ] 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)

Attachment 3.1-H

Health Homes Payment Methodologies

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Superseded SPA ID	new		

User-Entered

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

Attachment 3.1-H

Health Homes Payment Methodologies

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User-Entered

Rate Development

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 personnel cost, travel, and administration and general. The data for the rate computation was taken from actual expenditures of the contracted agency for the pilot demonstration, another agency who had bid for the pilot demonstration, and wage data from the Bureau of Labor and Statistics.

Salary models were built using FTE and salary information across benchmark data provided by:
- The contracted state-funded pilot demonstration provider;
- Another respondent to the pilot demonstration RFP; and
- Bureau of Labor and Statistics (BLS)

The staffing plan and respective FTEs for each ACIST team were initially established by DDDS 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 $67,650 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 $148,860 established for Psychiatric Nurse Practitioner is an average of the pilot agency, the non-selected RFP bidder and the 90th percentile of the BLS classification of “Nurse Practitioner”. The $69,633 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 established 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 that month. To receive the first 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 made 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.

Attachment 3.1-H

Health Homes Payment Methodologies

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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.

Describe below how non-duplication of payment will be achieved 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

Name	Date Created	
No items available		

Attachment 3.1-H

Health Homes Services

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	**Initial Submission Date**	10/18/2018
Approval Date	1/15/2019	**Effective Date**	10/1/2018
Superseded SPA ID	new		

User-Entered

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 re-evaluated 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
- [x] Other (specify)

Provider Type	Description
Certified ACIST Health Home Provider	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.

Care Coordination

Definition

Care Coordination is the implementation of the treatment plan with active member involvement through appropriate linkages, referrals, coordination, and follow-up to needed services and supports. Care coordination is designed to be delivered in a flexible manner best suited to the individual and family's preferences and to support goals that have been identified by developing linkages and skills in order to allow health home members to reach their full potential and increase their independence in obtaining and accessing services.

Care coordination duties include, but are not limited to:

Coordinating with all team members to ensure all objectives of the comprehensive, treatment are progressing;

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Scheduling and communicating appointment times, including arranging transportation and support if necessary;
Conducting referrals, facilitating linkages, and following up;
Monitoring; and
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
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
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 Promotion

Definition

Health promotion services include
- Encouraging and supporting health education for the member/family/support persons
- Coaching members/family/support persons about chronic conditions and ways to manage health conditions based on the member's preferences
- Connecting the member to self-care programs to help increase their understanding of their conditions and care plan
- Promoting engagement of the member and family/support persons in self-management and decision making
- Encouraging and facilitating routine preventive care such as flu shots and cancer screenings
- Linking the member to resources for smoking cessation management of member chronic conditions; self-help recovery resources; and other services based on member needs and preferences
- Assessing the member's and family/support persons' understanding of the member's health condition and motivation to engage in self-management

Health promotion may include the following elements:
- Mental health symptom management and mediation
- Individual counseling and/or behavior analysis as indicated in the individual's treatment plan
- Medication, monitoring, education and documentation
- Addiction treatment and education including counseling, relapse prevention, harm reduction,
- Anger and stress management, if appropriate

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

Attachment 3.1-H

- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
Certified ACIST Health Home Provider	Certified ACIST Health Home Provider All members of the team may participate in health promotion services for each individual. For service components requiring clinical skillsets, the appropriate team member will carry out and/or oversee those specific elements.

Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

The health home team will maintain continued contact with individuals during inpatient or other setting stays to help insure greater continuity of service both within the facility and upon discharge from the facility. Plans for transition back to community-based settings, including necessary clinical support throughout transition, will be initiated immediately upon admission in partnership with facility discharge planners and any providers of LTSS. The team of the individual hospitalized must meet with the client multiple times per week during acute admissions throughout their inpatient stay and have periodic planning sessions with the client's treatment team/treating medical professionals. ACIST team receives all relevant discharge information and facilitates all necessary appointments and/or coordination of services pursuant to those instructions.

At a minimum, the HH will:
• utilize 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 tor 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.

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
- [x] Other (specify)

Provider Type	Description
Certified ACIST Health Home Provider	Certified ACIST Health Home Provider Lead staff on the team to be determined by inpatient circumstances

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 insure that the individual's financial needs are met, coordinated and

monitored. In addition, the team will work with the individual as well as the payee to reach the goal of financial independence; however that is defined for the individual based on his/her needs and financial skills.

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
- [x] Other (specify)

Provider Type	Description
Certified ACIST Health Home Provider	Certified ACIST Health Home Provider All members of the team may participate in individual and family support services for each individual. For service components requiring clinical skill sets, the appropriate team member will carry out and/or oversee those specific elements.

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
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians

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- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
Certified ACIST Health Home Provider	Certified ACIST Health Home Provider Bachelor's level care manager within the team followed by his/her direct supervisor.

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Health Homes Services

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	**Initial Submission Date**	10/18/2018
Approval Date	1/15/2019	**Effective Date**	10/1/2018
Superseded SPA ID	new		
	User-Entered		

Health Homes Patient Flow

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

Name	Date Created	
DE ACIST Health Home Patient Flow	4/10/2018 2:00 PM EDT	

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Health Homes Monitoring, Quality Measurement and Evaluation

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

Package Header

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Superseded SPA ID	new		

User-Entered

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 and 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.

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Health Homes Monitoring, Quality Measurement and Evaluation

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

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User-Entered

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 measureable 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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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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 od Providers:

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):_____

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._____0ther
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
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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:

_____

_____

_____

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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.

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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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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.

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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

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;

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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

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;

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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.

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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, 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.

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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 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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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

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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:

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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

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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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;

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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;

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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.

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

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 CRF 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.

1915(i) State plan Home and Community-Based Services

Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. **Services.** *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

- Employment Navigation
- Financial Coaching Plus
- Benefits Counseling
- Non-Medical Transportation
- Orientation, Mobility, and Assistive Technology
- Career Exploration and Assessment
- Small Group Supported Employment
- Individual Supported Employment
- Personal Care (including option for self-direction)

2. **Concurrent Operation with Other Programs.** (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

○	**Not applicable**	
X	**Applicable**	
	Check the applicable authority or authorities:	
	☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* *(b) the geographic areas served by these plans;* *(c) the specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
	X	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*
		This 1915(i) SPA will run concurrently with the State's approved 1915(b)(4)

	Pathways waiver for the purposes of limiting providers for Employment Navigator and Transportation Services.			
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
	☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	X	§1915(b)(4) (selective contracting/limit number of providers)
	This 1915(i) SPA will run concurrently with the State's approved 1915(b)(4) Pathways waiver for the purposes of limiting providers for Employment Navigation and Transportation Services.			
☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*			
X	**A program authorized under §1115 of the Act.** *Specify the program*:			
	This 1915(i) SPA will run concurrently with the State's approved 1115 waiver.			

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one)*:

○	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	○	The Medical Assistance Unit *(name of unit)*:	
	X	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	The benefit will be administered by the following Division within the Delaware Department of Health and Social Services, the Single State Medicaid Agency. • Developmental Disabilities Services
○	The State plan HCBS benefit is operated by *(name of agency)*		

	a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.

4. Distribution of State plan HCBS Operational and Administrative Functions.

X *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	✓	☐	☐	☐
2 Eligibility evaluation	✓	☐	☐	☐
3 Review of participant service plans	✓	☐	☐	☐
4 Prior authorization of State plan HCBS	✓	☐	☐	☐
5 Utilization management	✓	☐	☐	☐
6 Qualified provider enrollment	✓	☐	✓	☐
7 Execution of Medicaid provider agreement	✓	☐	✓	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	✓	☐	☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	✓	☐	☐	☐
10 Quality assurance and quality improvement activities	✓	☐	☐	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

For items 7 and 8 above, Delaware contracts with a provider relations agent to perform specific administrative functions. Specific functions performed by this contractor include the ongoing enrollment of service providers, execution of the Medicaid provider agreement, and the verification of provider licensure, where applicable, on an annual basis.

Provider relations functions include:

- enrolling service providers
- executing provider agreements

For participant directed services, the contracted Fiscal Management entity will execute and hold provider agreements for providers employed by the individual receiving services.

(By checking the following boxes the State assures that):

5. X **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

6. X **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. X **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. X **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	July 1, 2019	June 30, 2020	500
Year 2	July 1, 2020	June 30, 2021	525
Year 3	July 1, 2021	June 30, 2022	550
Year 4	July 1, 2022	June 30, 2023	575
Year 5	July 1, 2023	June 30, 2024	600

2. X **Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. X **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

X The State does not provide State plan HCBS to the medically needy.
☐ The State provides State plan HCBS to the medically needy. (*Select one*):
☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services. ☐ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

X	Directly by the Medicaid agency
○	By Other (*specify State agency or entity under contract with the State Medicaid agency*):

2. **Qualifications of Individuals Performing Evaluation/Reevaluation**. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

For all target groups, the minimum qualifications for independent individuals performing initial evaluations for eligibility are as follows:

- State classification of Senior Social Worker/Case Manager or equivalent standards for education and experience, with additional disability-specific training provided as needed to effectively perform evaluation.

Minimally, this additional training will include training in assessment of individuals whose physical, cognitive, or mental conditions trigger a potential need for home and community-based services and supports, and current knowledge of available resources, service options, providers, and best practices to improve health and quality of life outcomes.

For all target groups, reevaluations are conducted by individuals holding an associate's degree or higher in a 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.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

To facilitate access to the benefit, Delaware will be utilizing the Aging and Disability Resource Center (ADRC) as an initial no wrong door entry point for individuals new to the delivery system. Individuals already enrolled or identified as eligible for Pathways through an operating division do not need to go through the ADRC before the process initiates. The ADRC will do a preliminary screening to determine interest in work and likely target group eligibility. This screen will collect information on employment interest, available service history information, and a preliminary review of target group. The ADRC will not actually perform an evaluation against the needs based criteria but will facilitate

the performance of the evaluation by the appropriate state entity by gathering information. The ADRC will perform a referral, conveying all applicable information to the Assessment manager within each division responsible for conducting evaluation. Referrals will occur on an ongoing basis, as individuals contact the ADRC. Protocols for referrals will be developed and overseen by the administering divisions and DMMA, with the aim being a seamless experience for individuals accessing the Pathways program.

The Assessment Manager, who may also serve as the conflict-free Employment Navigator conducting evaluations, assessment and plan of care development activities, will ensure the completion of the formal initial evaluation of whether the individual meets the targeting and needs-based criteria. This evaluation will include a thorough review of documentation such as the individual's medical history, visual acuity documented in accordance with state requirements, functional support needs related to activities of daily living (ADL), and cognitive and adaptive functioning, as applicable to the needs-based criteria for the appropriate target group.

The single state Medicaid agency will make final determinations regarding program eligibility.

Reevaluations will be conducted by a qualified professional as described in Item #2 above and will include a review to verify that individuals continue to meet the applicable needs-based criteria.

4. X **Reevaluation Schedule**. *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. X **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

Individuals who have a desire to work in a competitive work environment and for which the services provided herein are not otherwise available to the individual under either special education and related services as defined in section 602(16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401(16) and (17)) or vocational rehabilitation services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

Group A	Group B	Group C
Individuals who are Visually Impaired	Individuals with Physical Disabilities	Individuals with Intellectual Disabilities, Autism Spectrum Disorders or Asperger's Syndrome
Individuals are unemployed or underemployed or are at risk of losing their job without supports.	Individuals whose physical condition affects their ability to live independently, who need ongoing assistance with at least 1 ADL and who are at risk of being unable to sustain competitive employment without supports.	Individuals with significant limitations in adaptive function and/or who need assistance with at least one area of ADL, and/or who have difficulty understanding and interpreting social situations and who are unlikely to be able to obtain or sustain competitive employment without supports.

6. X **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)

Group A Individuals who are Visually Impaired Individuals are unemployed or underemployed or are at risk of losing their job without supports. Group B Individuals with Physical Disabilities Individuals whose physical condition affects their ability to live independently, who need ongoing assistance with at least 1 ADL and who are at risk of being unable to sustain competitive employment without supports. Group C Individuals with Intellectual Disabilities, Autism Spectrum Disorders or Asperger's Syndrome. Individuals with significant limitations in adaptive function and/or who need assistance with at least one area of ADL, and/or who have difficulty understanding and interpreting social situations and who are unlikely to be able to obtain or sustain competitive employment without supports.	The individual must have deficits in at least 2 ADLs.	Individual: 1) Has a diagnosis of intellectual or developmental disability and has been deemed eligible for services through the Division of Developmental Disabilities Services (DDDS). 2) Has been determined to meet ICF/IID level of care based on an assessment completed by a Qualified Intellectual Disability Professional that indicates the individual requires assistance in at least two of the following domains: ADLs, safety, household activities, community access, maintaining relationships, health maintenance, communication, psychological and active treatment services for maximum independence. The diagnosis of Intellectual or Developmental Disability is determined based on: 1) The administration of the Adaptive Behavior Assessment System (ABAS) or Vineland Adaptive Behavior Scale (VABS) by a licensed psychologist,	An Acute Hospital LOC is assigned to individuals that require the highest intensity of medical and nursing services provided within a structured environment providing 24-hour skilled nursing and medical care

		certified school psychologist or a licensed physician who practices psychiatry who certifies that the individual/applicant has significantly sub-average intellectual functioning or otherwise meets the following criteria: b. 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).	

*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. X **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

Delaware defines the following target groups:

Group A	Group B	Group C
Individuals who are Visually Impaired	Individuals with Physical Disabilities	Individuals with Intellectual Disabilities, Autism Spectrum Disorders or Asperger's Syndrome
Individuals age 14 to 25 determined by a doctor of optometry or ophthalmology to be: totally blind (no light perception), legally blind (20/200 in the better eye with	Individuals age 14 to 25 with a physical disability; whose physical condition is anticipated to last 12 months or more.	Individuals age 14 to 25 with intellectual developmental disorder attributed to one or more of the following: IQ scores of 2 standard deviations below the mean, autism spectrum disorder, Asperger's

correction, or a field restriction of 20 degrees or less) or severely visually impaired (20/70 to 20/200 in the better eye with correction).		disorder, Prader-Willi Syndrome, as defined in the APA Diagnostic and Statistical Manual, brain injury or neurological condition related to IDD that originates before age 22.

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box the State assures that):

8. X **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* 1	
ii.	**Frequency of services**. The state requires (select one):	
	○	**The provision of 1915(i) services at least monthly**
	X	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

(By checking the following box the State assures that):

1. X **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

   (Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

Settings in which Pathways participants live and where they receive 1915(i) HCBS meet the HCB settings requirements at 441.710(a)-(b).

Pathways participants typically live in their own home, the home of a family member (owned or leased by the participant/participant's family for personal use) or a provider managed residential setting. Individuals living in a Medicaid-funded provider managed setting can only be enrolled in Pathways if the setting meets with the requirements for HCBS residential settings, as articulated in the HCBS Settings Rule. As part of the evaluation process for entry into the program, Employment Navigators will determine where applicants reside and will not enroll any applicant that lives in a setting that does not comply with the requirements of the HCBS Settings Rule.

Pathways participants will receive HCBS in a variety of settings, including but not limited to their homes or home of a family member, community settings (such as libraries), provider offices and worksites.

We have concluded that participant homes and community settings are compliant with HCB settings requirements as a result of the following:

- Homes are owned or leased by the participant/participant's family for personal use
- Participant rights are respected
- Participant has access to the community

We have determined that provider offices and worksites are compliant with HCB settings requirements as a result of the following:

- The setting facilitates access to the community
- The setting facilitates interaction with non-disabled, non-Medicaid individuals
- The provider meets all qualifications prior to service delivery including training that emphasizes participant rights, privacy, dignity and respect
- Provider offices and worksites will be inspected as part of the provide approval process
- By its very nature, Supported Employment and Group Supported Employment will be considered to be compliant with HCB setting requirements because that service is delivered in the member's place of work.

As applicable, Delaware will use the criteria above to monitor continued compliance with HCB settings requirements for both residents and settings where participants receive HCBS on an ongoing basis. As part of their routine monitoring, Employment Navigators will ask questions to ensure participants continue to reside in HCBS settings and also receive Pathways services in settings that are compliant with HCB settings requirements. This monitoring may include participant and provider surveys as well as site reviews. Participants found to reside in non-compliant settings will be dis-enrolled from Pathways. Non-compliant HCB settings where HCBS are provided will no longer be allowed as service sites. When this applies to a provider setting or worksite, the provider will be instructed that it cannot provide the service in that site and must either provide services in a compliant setting or be removed as a qualified provider of HCBS.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. X There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. X Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. X The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

Face-to-Face Assessments are conducted by Employment Navigators employed by the State (see Provider Qualifications for the Employment Navigator service under "Services". These individuals must have a minimum of an associate's degree or higher in a 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.

Individuals performing face-to- face assessments will also receive training in assessment of individuals whose physical, cognitive, or mental conditions trigger a potential need for home and community-based services and supports, and current knowledge of available resources, service options, providers, and best practices to improve health and quality of life outcomes.

5. Responsibility for Development of Person-Centered Service Plan. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

POC development will be conducted by Employment Navigators employed by the State (see Provider Qualifications for the Employment Navigator service under "Services". These individuals must have a minimum of an associate's degree or higher in a behavioral, social sciences or a related field OR having 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.

Individuals who develop the plan of care will also receive training in assessment of individuals whose physical, cognitive, or mental conditions trigger a potential need for home and community-based services and supports, and current knowledge of available resources, service options, providers, and best practices to improve health and quality of life outcomes.

6. Supporting the Participant in Development of Person-Centered Service Plan. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

The Employment Navigator will actively support the individual in the development of their person-centered employment plan. The process will:

1. Include people chosen by the individual.
2. Provide necessary information, in a manner understandable to the individual, and support for the individual to ensure that he/she directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
3. Be timely and be scheduled at times and locations of convenience to the individual.
4. Reflect cultural considerations of the individual.
5. Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.
6. Offer the full array of choices to the individual regarding the services and supports they receive and from whom.
7. Include a method for the individual to request updates to the plan.

Participants will receive information about the employment planning process and available supports and information from the Employment Navigator in writing, verbally and via the Pathways website. Information will be made available initially prior to the employment planning meeting and ongoing during employment planning meeting updates, upon request by the participant or family member or at any time the Employment Navigator feels the participant needs to be reminded about available resources.

Information made available to the participant shall include, at a minimum, the purpose of the employment planning meeting, background information on person-centered planning and the participant's role in the person-centered planning process, information about the participant's ability to invite the individuals they want to participate in the employment planning process.

Additionally, the Employment Navigator may make available additional resources to help facilitate the person-centered planning process such as, but not limited to an interpreter and information in braille and large print, as necessary.

7. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

The Employment Navigator will inform individuals about all willing and qualified providers available from which to choose as part of the person-centered planning process. The Employment Navigator will also make the individual aware of available online resources that contain provider information sorted geographically.

Prior to the development of a care plan, participants and/or their legal guardians or representatives are provided with information about the freedom to choose among a set of qualified providers. Participants are also given a list of providers and can choose among these service providers. The information is provided to participants at least annually. In addition, provider lists will be available to participants at any time during their enrollment in the Pathways program.

Information will be provided to individuals in an accessible manner, taking into consideration individual's unique communication needs, including consideration for language and needed accessibility accommodations.

8. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

All POC are subject to review by an approving entity within the Single State Medicaid agency. In addition, in the performance of oversight functions, a representative sample of all POC will be reviewed to ensure compliance with all requirements.

9. **Maintenance of Person-Centered Service Plan Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

X	Medicaid agency	☐	Operating agency	☐	Case manager
☐	Other (*specify):*				

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Employment Navigation (Case Management)
Service Definition (Scope)*:*	
Employment Navigation service will assist participants in gaining access to needed employment and related supports. This service ensures coordination between employment and related supports and other State plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Employment Navigators are limited to employees of the State of Delaware as per an approved 1915(b)(4) selective contracting waiver.	

Employment Navigators are responsible for collecting information for evaluating and/or re-evaluating the individual's needs-based eligibility and for performing assessments to inform the development of the person-centered employment plan.

In the function of delivering Employment Navigation services the Employment Navigator will:

In the performance of providing information to individuals served through Pathways;

- Informs individuals about the Pathways HCBS services, required needs assessments, the person-centered planning process, service alternatives, service delivery options (opportunities for participant-direction), roles, rights, risks, and responsibilities.
- Informs individuals on fair hearing rights and assist with fair hearing requests when needed and upon request.

In the performance of facilitating access to needed services and supports;

- Collects additional necessary information including, at a minimum, preferences, strengths, and goals to inform the development of the individual's service plan.
- Assists the individual and his/her service planning team in identifying and choosing willing and qualified providers.
- Coordinates efforts and prompts the individual to ensure the completion of activities necessary to maintain Pathways program eligibility.

In the performance of the coordinating function;

- Coordinates efforts and prompts the individual to participate in the completion of a needs assessment to identify appropriate levels of need and to serve as the foundation for the development of and updates to the Employment service plan.
- Uses a person-centered planning approach and a team process to develop the individual's Employment Plan to meet the individual's needs in the least restrictive manner possible.
- Develops and updates the Employment service plan based upon the needs assessment and person-centered planning process annually, or more frequently as needed.
- Explores coverage of services to address individuals' identified needs through other sources, including services provided under the State Plan, Medicare, and/or private insurance or other community resources.
- Coordinates, as needed, with other individuals and/or entities essential in the delivery of services for the individual, including MCO care coordinators, as well 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 such other sources.
- Coordinates with providers and potential providers of services to ensure seamless service access and delivery.
- Coordinates with the individual's family, friends, and other community members to cultivate the individual's natural support network.

In the performance of the monitoring function;

• Monitors the health, welfare, and safety of the individual and the Employment Plan implementation through regular contacts at a minimum frequency as required by the department.

• Responds to and assesses emergency situations and incidents and ensure that appropriate actions are taken to protect the health, welfare, and safety of the individual.

• Reviews provider documentation of service provision and monitor individual progress on employment outcomes and initiate meetings when services are not achieving desired outcomes.

•Through the service plan monitoring process, solicits input from the individual and/or family, as appropriate, related to satisfaction with services.

Competitive and integrated employment, including self-employment, shall be considered the first option when serving persons with disabilities who are of working age.

Documentation is maintained that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.) or other sources.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

X	Categorically needy *(specify limits):*
	Federal Financial Participation (FFP) is not claimed for incentive payments, subsidies, or unrelated vocational training expenses.
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Employment Navigator			Comply with Department standards, including regulations, policies, and

Provider **The providers of this service will be limited per concurrent operation with the Pathways 1915(b)(4) waiver granting waiver of free choice of providers for this service, necessary to ensure conflict free status, access, and quality.**			procedures relating to provider qualifications. Individuals providing this service must be employed by the State of Delaware and must: • Have an associate's degree or higher in a 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. • 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 needs. • Comport with other requirements as determined by the Department.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Employment Navigator	Department or Designee	Initially and annually or more based on service monitoring concerns.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Career Exploration and Assessment

Service Definition (Scope)*:*

Career Exploration and Assessment is a person centered, comprehensive employment planning and support service that provides assistance for program participants to obtain, maintain, or advance in competitive employment or self-employment. It is a focused, time limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the State's minimum wage. The outcome of this service is documentation of the participant's stated career objective and a career plan, including any necessary education and training, used to guide individual employment support.

This service may include conducting community based career assessment. The assessment may include:

- conducting a review of the participant's work history, interests and skills;
- identifying types of jobs in the community that match the participant's interests, abilities, and skills;
- identifying situational assessments (including job shadowing or job tryouts) to assess the participant's interest and aptitude in a particular type of job; and/or
- developing a report that specifies recommendations regarding the participant's individual needs, preferences, abilities, and characteristics of an optimal work environment. The report must also specify if education, training, or skill development is necessary to achieve the participant's employment or career goals, with an indication of whether those elements may be addressed by other related services in the participant's service plan or other sources.

Services must be delivered in a setting that complies with HCB standards and in a manner that supports the participant's communication needs including, but not limited to, age appropriate communication, translation services for participants that are of limited English proficiency or who have other communication needs requiring translation.

The service also includes transportation as an integral component of the service, such as to a job shadowing opportunity, during the delivery of Career Exploration and Assessment.

Competitive and integrated employment, including self-employment, shall be considered the first option when serving persons with disabilities who are of working age.

Documentation is maintained that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
X	Categorically needy *(specify limits):*
	Career Exploration and Assessment may be authorized for up to 6 months in a benefit year, with multi-year service utilization and reauthorization only with explicit written Department approval. This service is not available to individuals who are eligible for or are receiving this benefit through vocational rehabilitation programs offered by the Division for the Visually Impaired (DVI). Federal Financial Participation (FFP) is not claimed for incentive payments, subsidies, or unrelated vocational training expenses.
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Career Exploration Agency	State Business License or 501 (c)(3) status	Pathways Certified Provider (utilizing DDDS HCBS Waiver Criteria)	Comply with all Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. Meet minimum standards as set forth by the Division of Vocational Rehabilitation or Division for the Visually Impaired as applicable for comparable services. Ensure employees 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 needs. Individuals employed by providers must:

			• Have criminal background investigations in accordance with state requirements. • Have a screening against the 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 and not have an adverse registry findings in the performance of the service. • Be state licensed (as applicable), or registered in their profession as required by state law. In the case of direct care personnel, possess certification through successful completion of training program as required by the Department.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Career Exploration Agency	Department or Designee	Initially and annually or more based on service monitoring concerns.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Supported Employment-Individual

Service Definition (Scope)*:*

Individual Supported Employment services are the ongoing supports provided, at a one-to-one participant to staff ratio, to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce. Jobs in competitive and customized employment must provide compensation at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Individual Supported Employment may also include support to establish or maintain self-employment, including home-based self-employment with business generated income for the individual. Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits support, training and planning, transportation, asset development and career advancement services, and other workplace support services including services not specifically related to job skill training that enable the participant to be successful in integrating into the job setting. Competitive and integrated employment, including self-employment, shall be considered the first option when serving persons with disabilities who are of working age to obtain employment. Services must be delivered in a manner that supports the participant's communication needs including, but not limited to, age appropriate communication, translation services for participants that are of limited-English proficiency, or who have other communication needs requiring translation. Services must be delivered in a setting that complies with HCB standards. Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).
Additional needs-based criteria for receiving the service, if applicable *(specify):*
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*

X	Categorically needy *(specify limits):*

	Individual Supported Employment does not include facility-based or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace. Individual Supported Employment services do not include volunteer work and may not be used for job placements paying below minimum wage. Job placement support provided as a component of this service is time-limited, requiring re-authorization every 90 days, up to 6 months in a benefit year months. At each 90-day interval, the service plan team will meet to clarify goals and expectations and review the job placement strategy. The Individual Supported Employment Services service provider must maintain documentation in accordance with Department requirements. Except as permitted in accordance with requirements contained in Department guidance, policy and regulations, this service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service. FFP is not claimed for incentive payments, subsidies, or unrelated vocational training expenses. Individual Supported Employment Services does not include payment for supervision, training, support, and adaptations typically available to workers without disabilities.
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Supported Employment Agency	State Business License or 501 (c)(3) status	Pathways Certified Provider (utilizing DDDS Waiver Criteria); and, DVR Vendor for Job Development, Placement and Retention Services	Comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. Meet minimum standards as set forth by the Division of Vocational Rehabilitation or Division for the Visually Impaired as applicable for comparable services. Ensure employees 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 needs.

			Individuals employed by providers must: • Have criminal background investigations in accordance with state requirements. • Have a screening against the 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 and not have an adverse 8564 and not have an adverse registry findings in the performance of the service. • Be state licensed (as applicable), or registered in their profession as required by state law. In the case of direct care personnel, possess certification through successful completion of training program as required by the Department

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Supported Employment Agency	**Department or Designee**	**Initially and annually (or more frequent based on service monitoring concerns)**

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Supported Employment-Small Group

Service Definition (Scope)*:*

Small Group Supported Employment are services and training activities provided in regular business, industry and community settings for groups of two (2) to no more than four (4) workers with disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Small Group Supported Employment must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces and be compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without

disabilities. The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Small Group Supported Employment does not include vocational services provided in facility based work settings, enclaves or other non-competitive or non-integrated job placements.

Small Group Supported Employment may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefits support, training and planning transportation and career advancement services. Other workplace support services may include services not specifically related to job skill training that enable the participant to be successful in integrating into the job setting.

Small Group Supported Employment emphasizes the importance of rapid job search for a competitive job and provide work experiences where the consumer can develop strengths and skills that contribute to employability in individualized paid employment in integrated community settings

Services must be delivered in a manner that supports the participant's communication needs including, but not limited to, age appropriate communication, translation services for participants that are of limited-English proficiency or who have other communication needs.

Services must be delivered in a setting that complies with HCB standards.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

X	Categorically needy *(specify limits):*

	Continuation of Small Group Supported Employment requires a review and reauthorization every 6 months in accordance with Department requirements, and shall not exceed 12 continuous months without exploration of alternative services. The review and reauthorization should verify that there have been appropriate attempts to prepare the consumer for a transition to Individualized Employment Support Services (IESS) and that the consumer continues to prefer Small Group Supported Employment, despite these attempts. Job placement support provided as a component of this service is time-limited, requiring re-authorization every 90 days, up to 6 months in a benefit year months. At each 90-day interval, the service plan team will meet to clarify goals and expectations and review the job placement strategy. Small Group Supported Employment does not include facility-based or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace. Small Group Supported Employment services do not include volunteer work and may not be for job placements paying below minimum wage. The Small Group Supported Employment Services service provider must maintain documentation in accordance with Department requirements. Except as permitted in accordance with requirements contained in Department guidance, policy and regulations, this service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service. FFP is not claimed for incentive payments, subsidies, or unrelated vocational training expenses. Small Group Supported Employment Services does not include payment for supervision, training, support, and adaptations typically available to workers without disabilities. Small Group Supported Employment services is not a pre-requisite for Individual Supported Employment.
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Supported Employment agency	State Business License or 501 (c)(3) status	Pathways Certified Provider (utilizing DDDS Waiver Criteria); and, DVR Vendor for Job	Comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. Meet minimum standards as set forth by the Division of Vocational Rehabilitation or Division for the Visually Impaired as

		Development, Placement and Retention Services	applicable for comparable services. Ensure employees 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 needs. Individuals employed by providers must: • Have criminal background investigations in accordance with state requirements. • Have a screening against the 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 and not have an adverse registry findings in the performance of the service. • Be state licensed (as applicable), or registered in their profession as required by state law. In the case of direct care personnel, possess certification through successful completion of training program as required by the Department.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Supported Employment Agency	Department or Designee	Initially and annually (or more frequent based on service monitoring concerns)

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Benefits Counseling

Service Definition (Scope)*:*
Benefits Counseling provides work incentive counseling services to Pathways to Employment participants seeking to work while maintaining access to necessary healthcare and other benefits. Benefits counseling will provide information to individuals regarding available benefits and assist individuals to understand options for making an informed choice about going to work while maintaining essential benefits. This service will assist individuals to understand the work incentives and support programs available and the impact of work activity on those benefits. This service will assist individuals to understand their benefits supports and how to utilize work incentives and other tools to assist them to achieve self-sufficiency through work. This service will also include the development and maintenance of proper documentation of services, including creating Benefits Summaries and Analyses and Work Incentive Plans. Services must be delivered in a setting that complies with HCB standards and in a manner that supports the participant's communication needs including, but not limited to, age appropriate communication, translation/interpretation services for participants that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding and use of communication devices used by the participant. This service is in addition to information provided by the Aging and Disability Resource Centers (ADRC), SHIP or other entities providing information regarding long-term services and supports. Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Delaware will ensure that individuals do not otherwise have access to this service through any other source, including SSA and WIPA.
Additional needs-based criteria for receiving the service, if applicable *(specify):*
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*

X	Categorically needy *(specify limits):*
	20 hours per year maximum with exceptions possible with explicit written Departmental approval.
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Benefits Counseling Agency	State Business License or 501 (c)(3) status		Comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. Ensure employees and/or contractors 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 needs. Individuals employed or contracted by providers must: • Have a screening against the 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 and not have an adverse registry findings in the performance of the service. • Be state licensed (as applicable), or registered in their profession as required by state law. In the case of direct care personnel, possess certification through successful completion of training program as required by the Department.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Benefits Counseling Agency	Department or Designee	Initially and annually (or more frequent based on service monitoring concerns)

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Financial Coaching Plus

Service Definition (Scope)*:*

Financial Coaching Plus uses a financial coaching model to assist individuals in establishing financial goals, creating a plan to achieve them, and providing information, support, and resources needed to implement stated goals in the financial plan. The financial coach will assist the client seeking to improve his/her financial well-being in order to improve economic self-sufficiency. Financial Coaching Plus includes the development of a personal budget and identifies reliable and trusted savings, credit, and debt programs that promote financial stability. The content and direction of the coaching is customized to respond to the individual financial goals set by the participant. Financial coaching is provided to the client one-on-one in a setting convenient for the client over a time-limited series of sessions and follow-up to increase the opportunity for self-directed behavior skills learning.

The Financial Coaching will:

- Assist the client in developing financial strategies to reach participant's goals with care to ensure that personal strategies reflect considerations related to benefits, as identified through benefits counseling;
- Ensure that individuals understand the availability of various tax credits such as the Earned Income Tax Credit, Child Care Tax Credit, and others;
- Refer individuals as needed to benefit counselors;
- Provide information to complement information provided through benefits counseling regarding appropriate asset building;
- Use an integrated dashboard of available community-based asset building opportunities and financial tools/services to ensure participants are leveraging all resources to increase economic self-sufficiency;
- Provide information about how to protect personal identify and avoid predatory lending schemes;
- Provide assistance with filing yearly taxes either through the IRS VITA program or its virtual program that involves self-filing.

The Financial Coaching Plus service will include the collection and maintenance of proper documentation of services provided as required by the Department that will track goals, actions, and outcomes of individual participants.

The Financial Coaching Plus service may complement information provided on the use of public benefits and/or work incentives through Benefits Counseling or other services.

Services must be delivered in a setting that complies with HCB standards.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.) or other services.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

X	Categorically needy *(specify limits):*
	Financial Coaching Plus service limited to five hours per participant per year.
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Financial Coaching Agency	State Business License or 501 (c)(3) status	An agency must demonstrate that Financial Coaches who will provide this service are certified in the financial coaching curriculum developed by the Department of Health and Social Services and the University of Delaware Alfred Lerner College of Business and Economics and the Division of Professional Continuing Studies.	Comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. The provider, including its parent company and its subsidiaries, and any sub provider, including its parent company and subsidiaries, agree to comply with the provisions of 29 Del Code Chapter 58, Laws Regulating the Conduct of Officers and Employees of the State and in particular with Section 5805 (d) Post Employment Restrictions. Ensure employees and/or contractors 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 needs. Individuals employed or contracted by providers must:

			• Have criminal background investigations in accordance with state requirements. • Have a screening against the 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 and not have an adverse registry findings in the performance of the service. • Be state licensed (as applicable), or registered in their profession as required by state law. • In the case of direct care personnel, possess certification through successful completion of training program as required by the Department. An agency must demonstrate that Financial Coaches who will provide this service: • Have at least one year of full time financial coaching experience. • Are trained in Financial Coaching Plus strategies specific to the Pathways population.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Financial Coaching Plus Agency	Department or Designee	Initially and annually (or more frequent based on service monitoring concerns)

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Non-Medical Transportation
Service Definition (Scope)*:*	
Service offered in order to enable participants to gain access to employment services, as specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the Pathways program are offered in accordance with the participant's service plan. Whenever possible and as determined through the person-centered planning process, family, neighbors, friends, carpools, coworkers, or community agencies which can provide this service without charge must be utilized. Non-medical Transportation services are offered, in addition to any medical transportation furnished under the 42 CFR 440.17(a) in the State Plan. Non-medical Transportation services are necessary, as specified by the service plan to enable individuals to gain access to employment services. In order to be approved, non-medical transportation would need to be directly related to a goal on the individual's treatment plan (e.g., to a supported employment) and not for the general transportation needs of the client (e.g., regular trips to the grocery store). This service will be provided to meet the individual's needs as determined by an assessment performed in accordance with Department requirements and as specifically outlined in the individual's POC. Transportation services will be delivered through a transportation broker who will arrange and/or provide services pursuant to the plan of care. Such transportation may also include public transportation. The utilization of public transportation promotes self-determination and is made available to individuals as a cost-effective means of accessing services and activities. This service provides payment for the individual's use of public transportation to access employment. The Employment Supports Coordinator will monitor this service quarterly and will provide ongoing assistance to the individual to identify alternative community-based sources of transportation. Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.) or any other source.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
X	Categorically needy *(specify limits):*
	The service does not provide for mileage reimbursement for a person to drive himself to work. Individuals may not receive this service at the same time as Supported Employment (individual or group) if those services are providing transportation to and from the employment setting.
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Transportation Broker Agency ***The providers of this service will be limited per concurrent operation with the Pathways 1915(b)(4) waiver of free choice of providers for this service, necessary to ensure conflict free status, access and quality.***	State Business License or 501 (c)(3) status	Broker	All drivers possess a valid driver's license. All vehicles are properly registered and insured.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Transportation Agency	Department or Designee	Initially and annually (or more frequent based on service monitoring concerns)

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Personal Care

Service Definition (Scope)*:*

Personal care includes assistance with ADLs (bathing, dressing, personal hygiene, transferring, toileting, skin care, eating and assisting with mobility), as needed to assist an individual in the workplace. When specified in the POC, this service may include assistance with instrumental activities of daily living (IADL) (e.g. task completion). Assistance with IADL's must be essential to the health and welfare of the participant. Personal care may also provide stand-by assistance in the workplace to individuals who may require support on an intermittent basis due to a disability or medical condition.

This service is intended to provide personal care for individuals in getting ready for work, in getting to work or at the workplace.

This service does not duplicate a service provided under the State plan as an expanded EPSDT service or services available to the individual through other Medicaid programs, including the DSHP Plus and any other Delaware HCBS waiver.

Personal Care may include escorting individuals to the workplace.

Services must be delivered in a setting that complies with HCB standards and in a manner that supports the participant's communication needs including, but not limited to, age appropriate communication, translation services for participants that are of limited-English proficiency or who have other communication needs.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

X	Categorically needy *(specify limits):*
	This service is over and above that which is available to the individual through the State Plan EPSDT benefit, the DSHP Plus program, or any other Delaware HCBS waiver, as applicable.
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home Health Agency	State Business License or 501 (c)(3) status; and State Home Health Agency License from Office of Health Facilities Licensing and Certification per Delaware Code Title 16-4406 Home Health Agencies (Licensure).	N/A	Comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. Complete and ensure employees 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 needs. Individuals employed by providers must: • Be at least 18 years of age.

			• Have criminal background investigations in accordance with state requirements. • Have a screening against the 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 and not have an adverse registry findings in the performance of the service. In the case of direct care personnel, possess certification through successful completion of training program as required by the Department.
Personal Assistance Services Agency	State Business License or 501(c)(3) status; and State Personal Assistance Services Agency License from Office of Health Facilities Licensing and Certification per Delaware Code Title 16-4469.	N/A	Comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. Complete and ensure employees 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 needs. Individuals employed by providers must: • Be at least 18 years of age. • Have criminal background investigations in accordance with state requirements. • Have a screening against the 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 and not have an adverse registry findings in the performance of the service. In the case of direct care personnel, possess certification through successful completion of training program as required by the Department.

Personal Attendant	N/A	N/A	• Must have the ability to carry out the tasks required by the participant. • Must have the ability to communicate effectively with the participant. • Have criminal background investigations in accordance with state requirements. • Have a screening against the 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 and not have an adverse registry findings in the performance of the service. • Must be at least 18 years of age. (Exceptions to the age requirement are made on a case-by-case basis and require written authorization by the participant case manager.) • Must complete training through Support for Participant Direction vendor within 90 days of enrollment as a provider. (Exceptions to the training requirement are made by the Support for Participant Direction vendor on a case-by-case basis for emergency back-up providers.)

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Home Health Agency	Department or Designee	Initially and annually (or more frequent based on service monitoring concerns)
Personal Assistance Services Agency	Department or Designee	Initially and annually (or more frequent based on service monitoring concerns)
Personal Attendant	Department or Designee	Initially and annually (or more frequent based on service monitoring concerns)

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Orientation, Mobility, and Assistive Technology

Service Definition (Scope)*:*

Assistive technology device means an item, piece of equipment or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device to increase independence in the workplace. Independent evaluations conducted by a certified professional, not otherwise covered under the State Plan services, may be reimbursed as a part of this service. Evaluations to determine need for assistive technology and to identify the appropriate technology to support individuals in employment settings are required. Assistive technology includes:

(A) the evaluation and assessment of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;

(B) the cost of the item, including purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;

(C) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;

(D) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;

(E) training, demonstrations and/or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and

(F) training, demonstrations and/or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

Assistive technology may include augmentative communication devices, adapted watches, high and low teach adaptive/assistive equipment such as video magnifiers, Braille displays, hardware and software.

Orientation and Mobility

Orientation and Mobility provides consumers training to develop the necessary skills to travel independently and safely. This is accomplished one on one with the usage of white canes, guide dogs, or other equipment. Orientation and Mobility instruction is a sequential process where visually impaired individuals are taught to utilize their remaining senses to determine their position within their environment and to negotiate safe movement from one place to another. This service does not duplicate a service provided under the State plan EPSDT benefit.

Items designed for general use shall only be covered to the extent necessary to meet the participant's assessed needs and are primarily used by a participant to address a therapeutic purpose.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.) or any other source.

Services must be delivered in a setting that complies with HCB standards.
Additional needs-based criteria for receiving the service, if applicable *(specify):*
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*

X	Categorically needy *(specify limits):*
	These assessments, items or services must not otherwise be available to individuals under the DSHP or DSHP Plus Program. Assistive Technology devices must be obtained at the lowest cost. The amount of this service for Assistive Technology devices is limited to $10,000 for the participant's lifetime. This amount includes replacement parts and repair when it is more cost effective than purchasing a new device. Exceptions to this limit may be considered based upon a needs assessment and prior authorization by the Department.
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Certified Orientation and Mobility Specialist	n/a	COMS	Meet minimum standards as set forth by Department of Vocational Rehabilitation or Division for the Visually Impaired as applicable for comparable services.
Certified Vision Rehabilitation Therapist	n/a	CVRT	Meet minimum standards as set forth by Department of Vocational Rehabilitation or Division for the Visually Impaired as applicable for comparable services.
Occupational Therapist	OTR/L	AOTA SCEM	Meet minimum standards as set forth by Department of Vocational Rehabilitation or Division for the Visually Impaired as applicable for comparable services.
Assistive Technology Professional	n/a	ATP RESNA Rehabilitation Engineering and	Meet minimum standards as set forth by Department of Vocational Rehabilitation or Division for the Visually Impaired as

		Assistive Technology Society of North America	applicable for comparable services.
Low Vision Therapist	n/a	LVT - Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP)	Meet minimum standards as set forth by Department of Vocational Rehabilitation or Division for the Visually Impaired as applicable for comparable services.
Durable Medical Equipment Suppliers	State Business License or 501 (c)(3) status		
Assistive Technology Suppliers	State Business License or 501 (c)(3) status		

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
All Provider Types	Department or Designee	Initially and annually (or more frequent based on service monitoring concerns)

Service Delivery Method. (*Check each that applies*):

☐	Participant-directed	X	Provider managed

2. X **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

(a) Spouses of participants may be paid to provide personal care services under the circumstances described below.

(b) Payment is authorized for spouses to provide only those personal care services designated in the care plan which respond to a specific deficit or deficits in a participant's capacity to carry out ADLs and/or IADLs and which represent extraordinary care not typically provided by spouses in the absence of these deficits. The service plan includes authorization for service hours that include only those services and supports not ordinarily provided by a spouse in the absence of ADL and/or IADL deficits, including such supports as health maintenance activities; bathing and personal hygiene; bowel or urinary evacuation; and feeding. Activities which might, in the absence of ADL and/or IADL deficits, be considered shared responsibilities of spouses or members of a household, such as shopping, cleaning, or bill payment, are not considered for reimbursement for spousal personal care attendants under the Pathways program, except under unusual circumstances and at the discretion of the Employment Navigator.

(c) Under this program, participants who choose to self-direct some or all of their personal care services have employer authority. A specified number of personal care hours are authorized in a participant's care plan based on his/her individual needs. The participant, as employer of a personal care provider, including a spousal provider, is responsible for making sure that the personal care service is delivered by his/her attendant in such a way as to address the specific ADL and/or IADLs noted in the care plan. Regular contact between the participant and the Employment Navigator, and the Support for Participant Direction provider ensure that the participant's service needs are being met, including those service needs being met by the spousal personal care attendant. Face-to-face visits between the Support for Participant Direction Provider and the participant are held at a minimum twice per year when the participant chooses to employ a spouse to provide some or all of his or her authorized personal care services.

(d) Delaware will ensure that information regarding DOL requirements are available to all providers.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (*Select one):*

○	The state does not offer opportunity for participant-direction of State plan HCBS.
X	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

2. Description of Participant-Direction. (Provide an overview of the opportunities for participant-*direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

Personal care is the only service offered under the 1915(i) for which there are self-direction opportunities. All participants in Pathways who receive personal care services are offered the opportunity for employer authority to self-direct these personal care services. Individuals are informed of the opportunity for self-direction during the person-centered planning process.

The Employment Navigator provides information, both verbally and in writing, about: the benefit, available supports (such as assistance from the fiscal management entity, what assistance is provided and how to contact the vendor/fiscal employer agent) and information regarding their responsibilities when they elect to self-direct personal care services.

Individuals (or parents in the case of minor children) may elect to serve as the employer of record for these services. Individuals receive information and assistance in support of participant direction and vendor/fiscal employer agent support from an entity(ies) contracted with the state for the provision of these services.

The vendor/fiscal employer agent function is performed as a Medicaid administrative activity.

3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

X	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive

	comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
Personal Care	X	☐
	☐	☐

5. Financial Management. (*Select one)* :

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
X	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. X **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

Voluntary Termination of Participant Direction

An individual who elects to receive participant-directed personal care services can elect to terminate participant direction at any time. The state ensures the continuity of services for and the health and welfare of the participant who elects to terminate participant-directed personal care services.

A participant who elects to terminate participant direction is able to receive personal care services through an agency, which has an agreement to provide such services under the Pathways program.

Employment Navigators shall facilitate a seamless transition to an alternative service delivery method so that there are no interruptions or gaps in services. Employment Navigators shall ensure that employees remain in place until alternative providers are obtained and are scheduled to provide services. Employment Navigators shall monitor the transition to ensure that the service is provided consistent with the employment plan and in keeping with the participant goals and objectives.

Involuntary Termination of Participant Direction

Participants who opt to self-direct some or all of their personal care service hours receive a great deal of support to assist them in carrying out their responsibilities. This support leads to successful participant-direction in most cases. However, there are a several circumstances under which the State would find it necessary to terminate participant direction. Specifically, the State involuntarily terminates the use of participant direction under the following circumstances:

- Inability to self-direct. If an individual consistently demonstrates a lack of ability to carry out the tasks needed to self-direct personal care services, including hiring, training, and supervising his or her personal care attendant, and does not have a representative available and able to carry out these activities on his/her behalf, then the State would find it necessary to terminate the use of participant direction.
- Fraudulent use of funds. If there is substantial evidence that a participant has falsified documents related to participant directed services (for example authorizing payment when no services were rendered or otherwise knowingly submitting inaccurate timesheets), then the State would find it necessary to terminate the use of participant direction.
- Health and welfare risk. If the use of participant direction results in a health and welfare risk to the participant that cannot be rectified through intervention on the part of the Support for Participant Direction provider and/or the Employment Navigator, then the State would find it necessary to terminate the use of participant direction.

In cases in which participant direction is discontinued, the Employment Navigator makes arrangements immediately with the participant to select from a list of provider-managed personal care entities (i.e., those home health agencies and personal assistance services agencies enrolled to provide the 1915 (i) services). Once the individual has selected a new personal care provider, the Employment Navigator makes arrangements to have the agency-based service begin as soon as possible to minimize or eliminate any possible gap in service.

Employment Navigators shall facilitate a seamless transition to alternative service delivery method so that there are no interruptions or gaps in services. Employment Navigators shall ensure that employees

remain in place until alternative providers are obtained and are scheduled to provide services. Employment Navigators shall monitor the transition to ensure that the service is provided consistent with the employment plan and in keeping with the participant goals and objectives.

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

○	The state does not offer opportunity for participant-employer authority.	
X	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	X	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

X	The state does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. **Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.**

2. **Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.**

3. **Providers meet required qualifications.**

4. **Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**

5. **The SMA retains authority and responsibility for program operations and oversight.**

6. **The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**

7. **The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.**

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	Settings meet the home and community-based settings requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (a)(2)
Discovery	
Discovery Evidence *(Performance Measure)*	1. The percentage of Pathways participants that are residing in settings that comply with HCB setting requirements. 2. The percentage of Pathways participants receiving Pathways services in settings that comply with HCB settings requirements.
Discovery Activity *(Source of Data & sample size)*	1. Record Review. Representative Sample; Confidence Interval = 95%

	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDDS
	Frequency	Continuously and Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	1. Employment Navigators in the operating divisions will regularly monitor the settings in which participants reside. Anyone found to no longer reside in an HCB setting will be dis-enrolled from the program. 2. Employment Navigators will regularly monitor the settings in which participants receive Pathways services. Non-compliant HCB settings will no longer be allowed as setting sites.
	Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement	Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
Discovery	
Discovery Evidence *(Performance Measure)*	1. The percentage of Pathways participants enrolled during the period who met the eligibility criteria prior to the initiation of Pathways services. 2. The percentage of Pathways participants that met initial eligibility when the eligibility criteria was applied correctly. 3. The percentage of Pathways participants whose eligibility was reevaluated at a minimum of annually.
Discovery Activity *(Source of Data & sample size)*	100% Record Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDDS

Frequency	Continuously and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The operating division will serve an active role in correcting identified problems. The division will aggregate and analyze the data for the program, and will utilize the Pathways Workgroup, which includes DMMA to lead program remediation strategies. Remediation is expected upon detection of issue. Issues are initially discussed among involved parties so as to clearly communicate findings and desired outcomes, followed by a written report reiterating those areas and the date by which issues must be resolved.
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually
Requirement	Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.
Discovery	
Discovery Evidence *(Performance Measure)*	Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers. 1. The number and percentage of persons that report that they helped develop their service plan. 2. Number and /or percent of participants with service plans consistent with their individual assessments. 3. The percentage of participants whose service plan contains documentation that the participant was supported to make an informed choice about their providers(s). (The number of participants whose service plans contain documentation that the participant was supposed to make an informed choice about their provider(s)/total number of participants whose plans were reviewed.)
Discovery Activity *(Source of Data & sample size)*	1. Record Review. Representative Sample; Confidence Interval = 95% 2. Record Review. Representative Sample; Confidence Interval = 95% 3. Record review. Representative Sample; Confidence Interval = 95%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDDS
Frequency	Continuously and Ongoing

Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The operating division will serve an active role in correcting identified problems. The division will aggregate and analyze the data for the program, and will utilize the Pathways Workgroup, which includes DMMA to lead program remediation strategies. Delaware will collect data to establish a benchmark against which future improvement will be measured. Remediation is expected upon detection of issue. Issues are initially discussed among involved parties so as to clearly communicate findings and desired outcomes, followed by a written report reiterating those areas and the date by which issues must be resolved.
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement	Providers meet required qualifications
Discovery	
Discovery Evidence *(Performance Measure)*	1. The percent of providers that meet the standards for provider qualification at annual review.
Discovery Activity *(Source of Data & sample size)*	1. Provider Record Review. Representative Sample; Confidence Interval = 95%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDDS
Frequency	Continuously and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The operating division will serve an active role in correcting identified problems. The division will aggregate and analyze the data for the program, and will utilize the Pathways Workgroup, which includes DMMA to lead program remediation strategies Remediation is expected upon detection of issue. Issues are initially discussed among involved parties so as to clearly communicate findings and desired outcomes, followed by a written report reiterating those areas and the date by which issues must be resolved.
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement	The SMA retains authority and responsibility for program operations and oversight
Discovery	
Discovery Evidence *(Performance Measure)*	1. Percent of needs based eligibility assessments where the decision of the reviewer was validated by DMMA 2. Number and percent of performance reports reviewed by the DMMA (Number of performance reports reviewed by DMMA/total number of performance reports). 3. Percent of DMMA's quarterly performance review meetings during which PTE quality assurance and improvement are discussed (Number of DMMA's quarterly meetings during which PTE QA/I are discussed/ all quarterly DMMA performance review meetings.)
Discovery Activity *(Source of Data & sample size)*	1. Record Review. Representative Sample; Confidence Interval = 95% 2. Administrative Records Representative Sample; Confidence Interval = 95% 3. Administrative records. Representative Sample; Confidence Interval = 95%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMMA
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The operating divisions will serve an active role in correcting identified problems, with DMMA providing oversight.
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
Discovery	
Discovery	1. Number and percent of rates adhering to reimbursement methodology in the approved

	Evidence *(Performance Measure)*	State plan amendment. 2. Percentage of service plans where services were delivered in accordance with service plan with regard to duration/frequency. (Number of Care Plans where services were delivered in accordance with POC in regard to duration/frequency as detailed in the service plan/Total number of Care Plans reviewed.)
	Discovery Activity *(Source of Data & sample size)*	1. Administrative Data and Record Review Representative Sample; Confidence Interval = 95% 2. Administrative data; Record Review Representative Sample; Confidence Interval = 95%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMMA
	Frequency	Continuously and Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The operating divisions will serve an active role in correcting identified problems. The divisions will aggregate and analyze the data and will utilize the Pathways Workgroup (which includes each operating division and DMMA) to lead cross-program remediation strategies. Remediation is expected upon detection of issue. Issues are initially discussed among involved parties so as to clearly communicate findings and desired outcomes, followed by a written report reiterating those areas and the date by which issues must be resolved.
	Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement	The State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.
Discovery	
Discovery Evidence *(Performance Measure)*	1. The percentage of incidents of Abuse/Neglect/Mistreatment that were reported in accordance with Pathways requirements. 2. The percentage of incidents of Abuse/Neglect/Mistreatment/Unexplained Death that occurs in a provider managed setting by type in which follow-up was completed in accordance with applicable Department requirements. 3. The percentage of employed participants reporting that they feel safe at work. (The number of participants reporting that feel safe at work/number of participants whose services and supports were reviewed)

	4. The percentage of reported incidents of emergency restrictive behavior intervention strategies implemented according to protocol per DDDS Behavioral and/or Mental Health Support Policy.
Discovery Activity *(Source of Data & sample size)*	1. Record Review. Representative Sample; Confidence Interval = 95% 2. Record Review. Representative Sample; Confidence Interval = 95% 3. Participant Questionnaire. Representative Sample; Confidence Interval = 95% 4. Representative Sample; Confidence Interval = 95%.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDDS
Frequency	Continuously and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The operating divisions will serve an active role in correcting identified problems. The divisions will aggregate and analyze the data and will utilize the Pathways Workgroup (which includes each operating division and DMMA) to lead cross-program remediation strategies. Remediation is expected upon detection of issue. Issues are initially discussed among involved parties so as to clearly communicate findings and desired outcomes, followed by a written report reiterating those areas and the date by which issues must be resolved.
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement	Employment Related Measures
Discovery	
Discovery Evidence *(Performance Measure)*	Percent of participants who: (a) have a paid job in the community (b) do not have a paid job in the community but would like to have a paid job in the community (c) like working at their job (d) would like to work someplace other than their current job (e) chose to work at their current job
Discovery Activity *(Source of Data &*	Participant Questionnaire; Representative Sample; Confidence Interval = 95%

	sample size)	
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDDS
	Frequency	Continuously and Ongoing (all PMs)
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The operating division will serve an active role in correcting identified problems. The division will aggregate and analyze the data for the program, and will utilize the Pathways Workgroup, which includes DMMA to lead program remediation strategies. Delaware will collect data to establish a benchmark against which future improvement will be measured. Remediation is expected upon detection of issue. Issues are initially discussed among involved parties so as to clearly communicate findings and desired outcomes, followed by a written report reiterating those areas and the date by which issues must be resolved.
	Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

System Improvement
(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

Through reports generated by target group and for the Pathways program as a whole, priorities will be established for systems improvements based upon the following hierarchy:

- Ensuring the health, safety and welfare of individuals served;
- Providing services in a manner consistent with a participant's service plan;
- Helping participants meet their individual employment objectives;
- Other systems improvements.

Also of paramount importance is to ensure the individual satisfaction of each participant and to ensure that they are getting needed services. That said, impediments to employment must be addressed swiftly and systematically to ensure the ongoing efficacy of the Pathways program.

2. Roles and Responsibilities

The Pathways Workgroup will routinely review aggregated discovery and remediation data to determine areas requiring systems improvement.

3. Frequency

Continuously and ongoing

4. Method for Evaluating Effectiveness of System Changes

Through data on interventions and through analysis of ongoing discovery data, the Workgroup will assess the effectiveness of the system improvement strategies.

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

X	HCBS Case Management
	The Employment Navigation rate is computed from annual provider costs from the prior period. The following list outlines the major allowable cost components used in rate development using federally accepted cost principles (2 CFR 200 cost principles). • Staffing Assumptions and Staff Wages • Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation) • Staff Productivity Assumptions (e.g., time spent on billable activities) • Program-Related Expenses (e.g., technology related expenses, supplies) • Provider Overhead Expenses Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of (insert services here). The agency's fee schedule rate was set as of 7/1/19 and is effective for services provided on and after that date. All rates are published on DDDS's website at the following address: https://dhss.delaware.gov/dhss/ddds/waiver_rates.html.
☐	HCBS Homemaker
☐	HCBS Home Health Aide
X	HCBS Personal Care
	Personal care rates are computed as a fixed percentage of the DMMA FFS rate for Home Health Aide services delivered by Home Health Agencies depending on the type of Pathways provider delivering Personal Care as follows: Home Health Agency Rate: 84% Personal Care Agency Rate: 73% Participant-directed Rate: 43% (the lower percentage reflects the removal of reimbursement for administrative functions included in the HHA rate). The DMMA HHR rate can be found in the Delaware Medicaid State Plan Attachment 4.19-B, pages 6 and 15. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of (insert services here). The agency's fee schedule rate was set as of 7/1/19 and is effective for services provided on and after that date. All rates are published on DDDS's website at the following address:

	https://dhss.delaware.gov/dhss/ddds/waiver_rates.html.	
☐	HCBS Adult Day Health	
☐	HCBS Habilitation	
☐	HCBS Respite Care	
For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
X	Other Services (specify below)	
	Career Exploration and Assessment The rate for Career Exploration and Assessment was calculated using a market basket methodology. • Staffing Assumptions and Staff Wages • Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation) • Staff Productivity Assumptions (e.g., time spent on billable activities) • Program Indirect Expenses (e.g., supplies) • Provider Overhead Expenses Wage data was obtained from authoritative sources such as the U.S. DOL Bureau of Labor Statistics for job classifications with similar requirements and duties as the direct support professionals performing this service in order to derive an appropriate DSP hourly wage rate. In developing the other rate components, provider cost data for the allowable costs included in the "market basket" was collected. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of (insert services here). The agency's fee schedule rate was set as of 1/1/15 and is effective for services provided on and after that date. All rates are published on DDDS's website at the following address: https://dhss.delaware.gov/dhss/ddds/waiver_rates.html.	
	Supported Employment – Individual	

The methodology and rate for Individual Supported Employment is the same as those computed under Delaware's Lifespan 1915(c) waiver (DE 0009). The Individual Supported Employment rate was calculated using a market basket methodology. This rate methodology is comprised of the following key components:

- Staffing Assumptions and Staff Wages
- Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation)
- Staff Productivity Assumptions (e.g., time spent on billable activities)
- Program Indirect Expenses (e.g., supplies)
- Provider Overhead Expenses

Wage data was obtained from authoritative sources such as the U.S. DOL Bureau of Labor Statistics for job classifications with similar requirements and duties as the direct support professionals performing this service in order to derive an appropriate DSP hourly wage rate. In developing the other rate components, provider cost data for the allowable costs included in the "market basket" was collected. These costs are converted to percentages that are multiplied by the direct support hourly wage rate as a set of recursive percentages in order to develop an hourly provider DSP rate.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of (insert services here). The agency's fee schedule rate was set as of 7/1/19 and is effective for services provided on and after that date. All rates are published on DDDS's website at the following address: https://dhss.delaware.gov/dhss/ddds/waiver_rates.html.

Supported Employment - Small Group

Rates for Small Group Supported Employment are the same as those computed under Delaware's Lifespan 1915(c) waiver (DE 0009). Small Group Supported Employment rates were calculated using a market basket methodology. This rate methodology is comprised of the following key components:

- Staffing Assumptions and Staff Wages
- Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation)
- Staff Productivity Assumptions (e.g., time spent on billable activities)
- Program Indirect Expenses (e.g., supplies)
- Provider Overhead Expenses

Wage data was obtained from authoritative sources such as the U.S. DOL Bureau of Labor Statistics for job classifications with similar requirements and duties as the direct support professionals performing this service in order to derive an appropriate DSP hourly wage rate. In developing the other rate components, provider cost data for the allowable costs included in the "market basket" was collected. These costs are converted to percentages that are multiplied by the direct support hourly wage rate as a set of recursive percentages in order to develop an hourly

	provider DSP rate. A separate rate is established for each group size, up to 4 HCBS recipients, by dividing by the base rate by the number of individuals in the group. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of (insert services here). The agency's fee schedule rate was set as of 7/1/19 and is effective for services provided on and after that date. All rates are published on DDDS's website at the following address: https://dhss.delaware.gov/dhss/ddds/waiver_rates.html.
	Non-Medical Transportation Non-Medical transportation will be implemented utilizing a transportation broker. The state will pay the broker on a fee-for-service basis with administrative compensation for the coordination and delivery of transportation. The rates will be one of the following, depending on the most direct, cost effective mode of transport: - Per mile (using established state reimbursement per mile) - Per public transportation trip using fees established by public transportation agency(ies) - Per trip, using a methodology based upon average miles per trip, number of individuals in transport and any specialized mode of transportation required.
	Benefits Counseling The rate for Benefits Counseling was calculated using a market basket methodology. This rate methodology is comprised of the following key components: • Staffing Assumptions and Staff Wages • Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation) • Staff Productivity Assumptions (e.g., time spent on billable activities) • Program Indirect Expenses (e.g., supplies) • Provider Overhead Expenses Wage data was obtained from authoritative sources such as the U.S. DOL Bureau of Labor Statistics for job classifications with similar requirements and duties as the direct support professionals performing this service in order to derive an appropriate DSP hourly wage rate. In developing the other rate components, provider cost data for the allowable costs included in the "market basket" was collected. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of (insert services here). The agency's fee schedule rate was set as of 1//1/15 and is effective for services provided on and after that date. All rates are published on DDDS's website at the following address: https://dhss.delaware.gov/dhss/ddds/waiver_rates.html.
	Financial Coaching Plus

The rate for Financial Coaching Plus was calculated using a market basket methodology. This rate methodology is comprised of the following key components:

- Staffing Assumptions and Staff Wages
- Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation)
- Staff Productivity Assumptions (e.g., time spent on billable activities)
- Program Indirect Expenses (e.g., supplies)
- Provider Overhead Expenses

Wage data was obtained from authoritative sources such as the U.S. DOL Bureau of Labor Statistics for job classifications with similar requirements and duties as the direct support professionals performing this service in order to derive an appropriate DSP hourly wage rate. In developing the other rate components, provider cost data for the allowable costs included in the "market basket" was collected.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of (insert services here). The agency's fee schedule rate was set as of 1//1/15 and is effective for services provided on and after that date. All rates are published on DDDS's website at the following address:
https://dhss.delaware.gov/dhss/ddds/waiver_rates.html

Orientation, Mobility, and Assistive Technology

The methodology and rates for Assistive Technology assessment and training are the same as those computed under Delaware's Lifespan 1915(c) waiver (DE 0009).

The rate for these services were calculated using a market basket methodology. This rate methodology is comprised of the following key components:

- Staffing Assumptions and Staff Wages
- Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation)
- Staff Productivity Assumptions (e.g., time spent on billable activities)
- Program Indirect Expenses (e.g., supplies)
- Provider Overhead Expenses

Wage data was obtained from authoritative sources such as the U.S. DOL Bureau of Labor Statistics for job classifications with similar requirements and duties as the direct support professionals performing this service in order to derive an appropriate DSP hourly wage rate. In developing the other rate components, provider cost data for the allowable costs included in the "market basket" was collected.

Assistive Technology devices are reimbursed based on the cost charged to the general public for the item.

	Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of (insert services here). The agency's fee schedule rate was set as of 1//1/15 and is effective for services provided on and after that date. All rates are published on DDDS's website at the following address: https://dhss.delaware.gov/dhss/ddds/waiver_rates.html

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

☑ No. Does not apply. State does not cover optional categorically needy groups.

☐ Yes. State covers the following optional categorically needy groups. *(Select all that apply):*

(a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used: *(Select one):*

☐ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

☐ OTHER (*describe*):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.
Income limit: (*Select one):*

☐ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (*Specify):* _____%

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):*

(c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s)):*

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 114 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.