PROMOTING OPTIMAL MENTAL HEALTH FOR INDIVIDUALS THROUGH SUPPORTS AND EMPOWERMENT (PROMISE) HOME AND COMMUNITY-BASED SERVICES

SERVICE CERTIFICATION AND REIMBURSEMENT MANUAL

STATE OF DELAWARE

February 1, 2025

The most recent version may be found at:
https://www.dhss.delaware.gov/dhss/dsamh/files/PROMISEManual.pdf

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Benefits Counseling

Service Specification	
Service Title:	Benefits Counseling

Service Definition (Scope)*:*

Benefits Counseling provides Work Incentive Counseling services to PROMISE program beneficiaries seeking to work while maintaining access to necessary healthcare and other benefits. Benefits Counseling will provide information to beneficiaries regarding available benefits and assist beneficiaries to understand options for making an informed choice about going to work, while maintaining essential benefits.

This service will assist beneficiaries to understand the work incentives and support programs available and the impact of work activity on those benefits. This service will assist beneficiaries 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 manner that supports the beneficiary's communication needs including, but not limited to, age-appropriate communication, translation/Interpretation services for beneficiaries that are of limited-English proficiency, or who have other communication needs requiring translation, and assistance with the provider's understanding and use of communication devices used by the beneficiary.

This service is in addition to information provided by the Aging and Disability Resource Centers, the State Health Insurance Assistance Program, 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 Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1401 et seq.), or any other source.

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

Beneficiaries may not have access to this service from any other source.

Specify limits (if any) on the amount, duration, or scope of this service for (chose each that applies):

X	***Categorically needy (specify limits):***
	Twenty (20) hours per year maximum, with exceptions possible with explicit, written Delaware Department of Health and Socials Services (DHSS) approval.
☐	***Medically needy (specify limits):***

Provider Qualifications			
Provider Type (Specify):	**License (Specify):**	**Certification (Specify):**	**Other Standard (Specify):**

Benefits Counseling Agency.	State Business License or 501(c)(3) status.	Community Partner Work Incentives Counseling Certification issued by an appropriate accrediting body, as authorized by the Social Security Administration.	• Comply with DHSS standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. • Ensure employees and/or contractors complete DHSS-required training, including training on the beneficiary's Recovery Plan and the beneficiary's unique and/or disability-specific needs, which may include, but are not limited to, communication, mobility, and behavioral needs. • Individuals employed or contracted a Benefits Counseling Agency must: – Have a screening against the child abuse and adult abuse registry checks, 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 finding 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 DHSS.

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.	DHSS or Designee.	Initially and annually (or more frequently, based on service monitoring concerns).

Service Delivery Method

Service Delivery Method (check each that applies):	☐	Participant-directed.	X	Provider managed.

Billing Method

Bill Code:	**Billing Rate and Unit:**
H2014 SE: • Skills training and development, per 15 minutes. • SE = State and/or Federally funded programs/services.	$17.28 per 15 minutes.

Care Management

Service Specification	
Service Title:	Care Management
Service Definition (Scope):	

Care Management includes services assisting beneficiaries in gaining access to needed demonstration 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. All PROMISE beneficiaries will receive Care Management. Care Managers are responsible for the ongoing monitoring of the provision of services included in the beneficiary's Recovery Plan and/or beneficiary's health and welfare. Care Managers are responsible for initiating the process to evaluate and/or reevaluate the beneficiary's level of care/needs-based eligibility and/or development of Recovery Plans.

The Care Manager will work with the beneficiary to identify barriers to individual goals, include services, natural supports, and community resources across episodes of care ensuring integrated community care and the health and welfare of the individual. The Care Manager will ensure that the four (4) functions of Care Management occur: assessment, Recovery Plan development, facilitating access and referral to needed services, and monitoring of services. The Care Manager will work with the Assertive Community Treatment/Intensive Care Management (ACT/ICM) teams, as well as Group Home providers, to ensure that the Care Management embedded within those teams is supported and that the Care Manager does not undermine the Evidence-Based Practice (EBP) team so long as person-centered planning and the beneficiary's personal goals are supported, and the services and supports needed by the beneficiary are delivered.

The function of the Care Manager is to produce a community-based, individualized Recovery Plan. This includes working with the beneficiary and/or family to identify who should be involved in the person-centered planning process. The Care Manager guides the Recovery Plan development process. The Care Manager is also responsible for subsequent Recovery Plan review and revision, as needed, at a minimum on a yearly basis, for beneficiaries to review the Recovery Plan, and more frequently when changes in the beneficiary's circumstances warrant changes in the Recovery Plan. The Care Manager will emphasize building collaboration and ongoing coordination among the family, caretakers, service providers, and other formal and informal community resources identified by the family and promote flexibility to ensure that appropriate and effective service delivery to the beneficiary and family/caregivers. Care Managers complete specialized training in the person-centered planning philosophy and 1915(i)-like Home- and Community-based services (HCBS) rules and processes, service eligibility and associated paperwork, and meeting facilitation.

When a beneficiary is receiving PROMISE services, the Care Manager must ensure that the provider maintains documentation and that the Care Manager monitors the services on an ongoing basis to ensure that the health and welfare of the beneficiary is met, and the Recovery Plan goals are achieved. The documentation must be available to the Care Manager for monitoring at all times on an ongoing basis. Documentation in accordance with Department requirements must be maintained in the beneficiary's file by the Care Manager and updated with each reauthorization, as applicable.

The Care Manager's responsibilities include initiating the process to evaluate and/or re-evaluate the beneficiary's level of care and/or development of Recovery Plans; assisting the beneficiary in gaining access to needed services regardless of the funding source; providing ICM for PROMISE members in need of Supports services through recovery planning and coordination to identify services; brokering services to obtain and integrate services, facilitation, and advocacy to resolve issues that impede access to needed services; monitoring and reassessing services based on changes in the beneficiary's condition; gate keeping to assess and determine the need for services; and ongoing monitoring of the provision of services included in the beneficiary's Recovery Plan and/or beneficiary health and welfare.

In the performance of providing information to beneficiaries, the Care Manager will:

- Inform beneficiaries about the HCBS services, required needs assessments, person-centered planning process, service alternatives, service delivery options (opportunities for beneficiary-direction), roles, rights, risks, and responsibilities.
- Inform beneficiaries 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, the Care Manager will:
- Collect additional necessary information including, at a minimum, beneficiary preferences, strengths, and goals to inform the development of the person-centered Recovery Plan.

- Assist the beneficiary and his/her Recovery Planning team in identifying and choosing willing and qualified providers.
- Coordinate efforts and prompt the beneficiary to ensure the completion of activities necessary to maintain HCBS program eligibility.
- In the performance of the coordinating function, the Care Manager will:
- Coordinate efforts in accordance with DHSS requirements and prompt the beneficiary to participate in the completion of a needs assessment, as required by the State, to identify appropriate levels of need and to serve as the foundation for the development of and updates to the Recovery Plan.
- Use a person-centered planning approach and a team process to develop the beneficiary's Recovery Plan to meet the beneficiary's needs in the least restrictive manner possible. At a minimum, the approach shall:
    - Include people chosen by the beneficiary for Recovery Plan meetings, review assessments, include discussion of needs, to gain understanding of the beneficiary's preferences, suggestions for services, and other activities key to ensure development of a person-centered Recovery Plan.
    - Provide necessary information and support to ensure that the beneficiary directs the process to the maximum extent possible and is enabled to make informed choices and decisions.
    - Be timely and occur at times and locations of convenience to the beneficiary.
    - Reflect cultural considerations of the beneficiary.
    - Include strategies for solving conflict or disagreement within the process.
    - Offer choices to the beneficiary regarding the services and supports they receive and the providers who may render them.
    - Inform beneficiaries of the method to request updates to the Recovery Plan.
    - Ensure and document the beneficiary's participation in the development of the Recovery Plan.
- Develop and update the Recovery Plan in accordance with State requirements, based upon the standardized needs assessment and person-centered planning process, annually, or more frequently as needed.
- Explore coverage of services to address beneficiary-identified needs through other sources, including services provided under the State Plan, Medicare, and/or private insurance or other community resources. These resources shall be used until the State Plan limitations have been reached or a determination of non-coverage has been established, and prior to any service's inclusion in the Recovery Plan, in accordance with DHSS standards.
- Actively coordinate with other individuals and/or entities essential in the physical and/or behavioral care delivery for the beneficiary, including Managed Care Organization (MCO) Care Coordinators, to ensure seamless coordination between Physical, Behavioral, and Support services.
- Coordinate with providers and potential providers of services to ensure seamless service access and delivery.
- Coordinate with the beneficiary's family, friends, and other community members to cultivate the beneficiary's natural support network, to the extent that the beneficiary (adult) has provided permission for such coordination.
- In the performance of the monitoring function, the Care Manager will:
- Monitor the health, welfare, and safety of the beneficiary and Recovery Plan implementation through regular contacts (monitoring visits with the beneficiary, paid and unpaid caregivers, and others) at a minimum frequency, as required by DHSS.
- Respond to and assess emergency situations and incidents, and assure that appropriate actions are taken to protect the health, welfare, and safety of the beneficiary.
- Review provider documentation of service provision, monitor beneficiary progress on outcomes, and initiate Recovery Plan team discussions or meetings when services are not achieving desired outcomes. Outcomes include housing status, employment status, involvement in the criminal justice system, response to treatment and other services, and satisfaction with services.

- Through the Recovery Plan monitoring process, solicit input from beneficiary and/or family, as appropriate, related to satisfaction with services.
- Arrange for modifications in services and service delivery, as necessary, to address the needs of the beneficiary, consistent with an assessment of need and DHSS requirements, and modify the Recovery Plan accordingly.
- Advocate for continuity of services, system flexibility and integration, proper utilization of facilities and resources, accessibility, and beneficiary rights.
- Participate in any DHSS-identified activities related to quality oversight.

Certified Peer Specialists who work for Care Management Agencies assist Care Managers with developing the Recovery Plan, facilitating access and referral to needed services, and monitoring services. Peers do not conduct comprehensive needs assessments or eligibility evaluations.

Ensure that beneficiaries are aware of how to access the Eligibility and Enrollment Unit (EEU) call center and 24-hour crisis staff for response to emergency situations, and that Care Manager are informed of any crises that occur.

Care Management includes functions necessary to facilitate community transition for beneficiaries who received Medicaid-funded Institutional services (i.e., Intermediate Care Facility, Nursing Facility, and Institution for Mental Disease (IMD)) or who lived in an institution for at least 90 consecutive days prior to their transition to the waiver. Care Management activities for beneficiaries leaving institutions must be coordinated with, and must not duplicate, Institutional Discharge Planning. This service may be provided up to 90 days in advance of anticipated movement to the community. The Care Manager must work with the community providers, including the ACT/ICM teams, to ensure that the services and supports are proactively in place.

The maximum caseload for a Care Manager providing services through this waiver is set by Medicaid or its designee, which includes beneficiaries in other waiver programs and other funding sources, unless the requirement is waived by DHSS.

Care Management Agencies must use an information system, as approved and required by DHSS, to maintain case records in accordance with DHSS requirements.

Services must be delivered in a manner that supports the beneficiary's communication needs including, but not limited to, age appropriate communication, translation/Interpretation services for beneficiaries that are of limited-English proficiency, or who have other communication needs requiring translation, and assistance with the provider's understanding and use of communication devices used by the beneficiary.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Depending upon whether a lead Care Manager is assisted by a Peer Care Manager or not, the average number of units necessary per beneficiary per year will vary depending upon the acuity of the beneficiary and the type of services that the beneficiary will receive. The Recovery Plan should reflect the following:

Level	High Touch	Medium Touch	Low Touch
	Tiers 1 and 2 Residential Setting[1]; Substance Use Disorder (SUD) Residential; Outpatient Mental Health, SUD, ACT Plus; or Co-Occurring Disorder (COD)	Tiers 3 and 4 Residential Setting[2]; Diamond State Health Plan Plus[3]	ACT/ICM Team, Preadmission Screening and Resident Review (PASRR) (*Note: PASRR not PROMISE eligible*)
Estimated time per year when performed solely by Lead Care Manager	67.5 hours	46 hours	17.5 hours
Estimated time for Lead Care Manager when assisted by	40.5 hours	27.5 hours	11.5 hours

Peer Care Manager			
Estimated time for the Peer Care Manager	27 hours	18.5 hours	6 hours

[1] Assumes Peer Specialist will help with Recovery Plan revision, referral assistance, coordination with providers/benefit coordination, monitoring visits, and telephone contacts; the total number of contacts remains the same as in the framework when not partnered with a Peer Specialist.

[2] Assumes beneficiaries in Community-based Residential settings must be seen at least once a month; these tiers have less staff involvement and supervision, thus more Care Manager involvement.

[3] Assumes beneficiaries in Community-based Residential settings must be seen at least once a month; these tiers have staff on site offering more support, thus less Care Manager involvement.

The following activities are excluded from Care Management as a billable waiver service:

- Outreach or eligibility activities (other than Transition services) before beneficiary enrollment in the waiver.
- Travel time incurred by the Care Manager may not be billed as a discrete unit of service.
- Services that constitute the administration of another program, such as Child Welfare or Child Protective Services, parole and probation functions, Legal services, Public Guardianship, Special Education, and Foster Care.
- Representative payee functions.
- Other activities identified by DHSS.

Care Management must be conflict free, and may only be provided by agencies and beneficiaries employed by agencies who are not:

- Related by blood or marriage to the beneficiary, or to any paid service provider of the beneficiary.
- Financially or legally responsible for the beneficiary.
- Empowered to make financial or health-related decisions on behalf of the beneficiary.
- Sharing any financial or controlling interest in any entity that is paid to provide care for or conduct other activities on behalf of the beneficiary.
- Beneficiaries employed by agencies paid to render direct or indirect services (as defined by DHSS) to the beneficiary, or an employee of an agency that is paid to render direct or indirect services to the beneficiary.

Claims for costs incurred on behalf of beneficiaries transitioning from an institutional setting may only be paid after the transition to the community.

Except as permitted in accordance with requirements contained in DHSS 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 (i.e., Care Management may not be billed concurrent with the provision of ACT/ICM, unless there is a specific DHSS policy that allows billing like attendance at a Plan of Care development meeting where the ACT team is present).

Care Managers must either be employed by a State agency or work for a provider agency with an executed contract with the State of Delaware.

Provider Specifications						
Provider Category(s) (check one or both):	☐	Individual (list types):	X	Agency (list types):		
			State Agency Staff. Care Management Agency.			
Specify whether the service may be provided by (check each that applies):	☐	Legally Responsible Person.	☐	Relative/Legal Guardian.		

Provider Qualifications			
Provider Type:	**License (specify):**	**Certificate (specify):**	**Other Standard (specify):**
State Agency Staff.			• Care Managers employed by the State must: — Be at least 18 years of age. — Have at least a bachelor's degree in education, psychology, social work, or other related social sciences, OR — Have at least a bachelor's degree in another discipline, with at least 12 credits in education, psychology, social work, or other related social sciences and at least one (1) year experience in working with people with serious and persistent mental illness (SPMI), serious mental illness (SMI),or SUD, OR — Comply with DHSS standards, including regulations, contract requirements, policies, andprocedures relating to provider qualifications. — Complete DHSS-required training, including training on the beneficiary's Recovery Plan and the beneficiary's unique and/or disability specific needs, which may include, but are not limited to, communication, mobility, and behavioral needs. — Complete required training developed by DHSS forCare Management, including training in needs assessment and person-centered planning. — Complete a professional background check. — Have a valid driver's license if the operation of a vehicle is necessary to provide the service. • State-employed Peer Specialists on a CareManagement Team must: — Be at least 21 years old. — Have a high school diploma or equivalent. — Be certified in the State of Delaware to provide the service, which includes criminal, abuse/neglect registry, and professional background checks, and completion of a State-approved standardized basictraining program. — Self-identify as having lived experience of mental illness and/or substance abuse as a present or former primary beneficiary or survivor of mental health and/or SUD services.
Care Management Agency.			• Agencies must have an executed contract with theState of Delaware and: — Comply with State regulations and policies and have a waiver provider agreement. — Comply with DHSS standards, including regulations, contract requirements, policies, andprocedures relating to provider qualifications. — Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet theunique needs of the beneficiary (e.g., communication, mobility, and behavioral needs).

			— Comply with and meet all standards as applied through each phase of the standard, annual DHSS-performed monitoring process. — Ensure 24-hour access to personnel (via direct employees or a contract) for response to emergency situations that are related to the Care Management service or other waiver services. • Care Managers must: — Be at least 21 years of age. — Have at least a bachelor's degree in education, psychology, social work, or other related social sciences, OR — Have at least a bachelor's degree in another discipline, with at least 12 credits in education, psychology, social work, or other related social sciences and at least one (1) year experience in working with people with SPMI, SMI, or SUD, OR — Comply with DHSS standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. — Complete DHSS-required training, including training on the beneficiary's Recovery Plan and the beneficiary's unique and/or disability specific needs, which may include, but are not limited to, communication, mobility, and behavioral needs. — Complete required training developed by DHSS for Care Management, including training in needs assessment and person-centered planning. — Complete a professional background check. — Have a valid driver's license if the operation of a vehicle is necessary to provide the service. • Peer Specialists on a Care Management Agency teammust: — Be at least 21 years old. — Have a high school diploma or equivalent. — Be certified in the State of Delaware to provide the service, which includes criminal, abuse/neglect registry, and professional background checks, and completion of a State-approved standardized basictraining program. — Self-identify as having lived experience of mental illness and/or substance abuse as a present or former primary beneficiary or survivor of mental health and/or SUD services.

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

Provider Type:	***Entity Responsible for Verification:***	***Frequency of Verification:***
State Agency Staff.	DHSS or designee.	At least annually (and more frequently, as deemed necessary by DHSS).
Care Management Agency.	DHSS or designee.	At least annually (and more frequently, as deemed necessary by DHSS).

Service Delivery Method				
Service Delivery Method (check each that applies):	☐	Participant-directed.	X	Provider managed.

Billing Method	
Bill Code:	**Billing Rate and Unit:**
Care Management (without Peer) T2022 TG: • Case management, per month. • TG = Complex/high-tech level of care. T2022 TF: • Case management, per month. • TF = Intermediate level of care. T2022: • Case management, per month.	Care Management (without Peer) • High touch: $625.73 per month. • Medium touch: $426.33 per month. • Low touch: $162.13 per month.
Care Management (with Peer) T2022 HT TG: • Case management, per month. • HT = Multi-disciplinary team. • TG = Complex/high-tech level of care. T2022 HT TF: • Case management, per month. • HT = Multi-disciplinary team. • TF = Intermediate level of care. T2022 HT: • Case management, per month. HT = Multi-disciplinary team.	Care Management (with Peer) • High touch: $ 508.19 per month. • Medium touch: $346.03 per month. • Low touch: $136.01 per month.

Community Psychiatric Support and Treatment

Service Specification	
Service Title:	Community Psychiatric Support and Treatment (CPST)

Service Definition (Scope)*:*

CPST services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid-eligible adults with significant functional impairments, meeting the need levels in the PROMISE program, resulting from an identified mental health or SUD diagnosis. The medical necessity for these Treatment and Rehabilitative services must be determined by a Licensed Behavioral Health Practitioner (LBHP) or Physician, who is acting within the scope of his/her professional license and applicable State law and furnished by or under the direction of a Licensed Practitioner, to promote the maximum reduction of symptoms and/or restoration of a beneficiary to his/her best age-appropriate functional level. The LBHP or Physician may conduct an assessment consistent with State law, regulation, and policy. A unit of service is defined according to the Healthcare Common Procedure Coding System (HCPCS) approved code set, unless otherwise specified.

Definitions:

The services are defined as follows:

- CPST are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the beneficiary's Recovery Plan. CPST is a face-to-face intervention with the beneficiary present; however, family or other collaterals may also be involved. This service may include the following components:
  - Assisting the beneficiary and family members or other collaterals to identify strategies or treatment options associated with the beneficiary's mental illness and/or SUD, with the goal of minimizing the negative effects of symptoms or emotional disturbances or associated environmental stressors, which interfere with the beneficiary's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.
  - Providing the beneficiary supportive counseling, solution-focused interventions, emotional and behavioral management support, and behavioral analysis with the beneficiary, with the goal of assisting the beneficiary with developing and implementing social, interpersonal, self-care, daily living, and independent living skills to restore stability, to support functional gains and to adapt to community living.
  - Facilitating participation in and utilization of strengths-based planning and treatments, which includes assisting the beneficiary 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 and/or SUD.
  - Assisting the beneficiary with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the beneficiary 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.
  - Providing restoration, rehabilitation, and support to develop skills to locate, rent, and keep a home, to enable landlord/tenant negotiations; selecting a roommate and understanding and exercising renter's rights and responsibilities.
  - Assisting the beneficiary in developing daily living skills specific to managing their own home including managing their money, medications, and using community resources and other self-care requirements.
  - Implementing interventions using evidence-based techniques, drawn from cognitive-behavioral therapy and other evidence-based psychotherapeutic interventions that ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom manifestation.

Additional medical necessity criteria for receiving the service, if applicable (specify):

For beneficiaries not receiving ACT/ICM, medical necessity criteria includes the following:

- The service is recommended by a LBHP or Physician acting within the scope of his/her professional license, AND
- The service is included in the beneficiary's Recovery Plan, AND
- The service is needed to allow the beneficiary the best opportunity to remain in the community, AND
- The service is directed at developing skills or achieving specific outcome(s) such as: increasing community tenure/inclusion/participation, enhancing personal relationships; establishing support networks; increasing independence/productivity; developing daily living skills to improve self-management of the effects of psychiatric or emotional symptoms that interfere with daily living; effectively responding to or avoiding identified precursors or triggers that result in functional impairments; increasing or maintaining personal self-sufficiency; and/or developing coping strategies and effective functioning in the social environment, including home, work and school, AND
- The beneficiary requires involvement of a LBHP to help develop and achieve these outcomes, AND
- The frequency and intensity of the service aligns with the unique needs of the beneficiary. Examples include:
  - A beneficiary being discharged from an Inpatient setting after three (3) admissions in six (6) months has a goal of being able to better self-manage the ongoing symptoms of his mental illness and identifies the need for three (3) hours per week of CPST for the next three (3) months to help him identify triggers for impulsive and self-injurious behaviors, develop a person-centered crisis management plan, provide supportive therapy, and to develop and monitor progress with psychosocial rehabilitation (PSR) services.
  - A beneficiary with a goal of improving her relationship with her family identifies the need for CPST once every two (2) weeks to assess progress and make modifications when indicated to services that are being provided to help her achieve this goal.

For beneficiaries receiving ACT, medical necessity criteria includes the following:

- ACT admission criteria (see Appendix 1 Section 3.1 for a complete listing of admission criteria):
  - Must be certified by the Psychiatric prescriber.
  - SPMI that seriously impairs a beneficiary's ability to live in the community.
  - Priority is for beneficiaries with Schizophrenia, other psychotic disorders, Bipolar Disorder.
  - Must have primary mental health diagnosis or COD.
  - Beneficiaries with only SUD/ıntellectual Developmental Disabilities (IDD), brain injury, or personality disorder **are not intended recipients.**
  - May have repeated hospitalizations with SUD issues.
  - Must meet at least one (1) of the criteria at Appendix 1, 3.1.1; 3.1.2; or 3.1.3) which generally include:
    - Difficulty performing daily tasks for basic adult functioning in the community (e.g., personal business; obtaining medical, legal, and housing services; recognizing and avoiding common dangers to self and possessions; meeting nutritional needs; maintaining personal hygiene).
    - Significant difficulty maintaining consistent employment at a self-sustaining level, or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks).
    - Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).
    - High use of Acute Hospitals (two (2) or more admissions per year) or Psychiatric Emergency services.
    - Intractable (persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).
    - Co-occurring substance use and SPMI or SMI of significant duration (e.g., greater than six (6) months).
    - High risk or recent history of criminal justice involvement (e.g., arrest and incarceration).
    - Significant difficulty meeting basic survival needs, residing in substandard housing, homeless, or at imminent risk of becoming homeless.

  - Residing in an inpatient or Supervised Community Residence, but clinically assessed to be able to live in a more independent living situation if Intensive services are provided, or requiring a residential or institutional placement if more Intensive services are not available.
  - Difficulty effectively utilizing traditional office-based Outpatient services or other less-intensive community-based programs (e.g., beneficiary fails to progress, drops out of services).
- Admission documentation must include:
  - Evidence that one (1) of the criteria in Appendix 1 at 3.1.1; 3.1.2; or 3.1.3 is met.
  - The reasons for admission are stated by BOTH the beneficiary and ACT team.
  - Signature of the Psychiatric prescriber.
  - Engagement/enrollment into ACT must begin within five (5) days of referral to ACT.
  - A review of medical necessity can be initiated at any time, but treatment team notes must regularly reflect all life domains and ongoing medical necessity of services.
- ACT discharge criteria:
  - Minimum of four (4) hours of services per month.
  - If fewer than four (4) hours is provided during the course of six (6) months due to recovery progress, the level of care must be evaluated.
  - Changes in recovery plan goals.
  - Plans for continuing care in the next month.

For beneficiaries receiving ICM, medical necessity criteria includes the following:

- ICM admission criteria (see Appendix 2 Section 3.1 for a complete listing of admission criteria):
  - Must be certified by the Psychiatric prescriber.
  - SPMI that seriously impairs a beneficiary's ability to live in the community.
  - Priority is for beneficiaries with Schizophrenia, other psychotic disorders, Bipolar Disorder.
  - Must have primary mental health diagnosis or COD.
  - Beneficiaries with only SUD/IDD, brain injury, or personality disorder **are not intended recipients.**
  - May have repeated hospitalizations with SUD issues.
  - Diagnoses that would otherwise be excluded from ICM services may be considered for an ICM team if an assessment by the team supports ICM services as the best course of action.
  - Must meet the admission criteria in Appendix 2 at 3.1.2.:
    - Difficulty performing daily tasks for basic adult functioning in the community (e.g., personal business; obtaining medical, legal, and housing services; recognizing and avoiding common dangers to self and possessions; meeting nutritional needs; maintaining personal hygiene).
    - Significant difficulty maintaining consistent employment at a self-sustaining level, or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks).
    - Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).
    - Continuous high service needs as demonstrated by at least one (1) of the following:
      - Co-occurring substance use and SPMI or SMI of significant duration (e.g., greater than six (6) months).
      - High risk or recent history of criminal justice involvement (e.g., arrest and incarceration).
      - Difficulty effectively utilizing traditional office-based Outpatient services or other less-intensive community-based programs (e.g., beneficiary fails to progress, drops out of services).
- ICM discharge criteria:
  - Requests for discharge from services shall occur when a beneficiary:
    - Has successfully reached individually established goals (i.e., demonstrates an ability to function in all major role areas such as work, social, self-care) for discharge, and when the beneficiary and program staff mutually agrees to the transition to less intensive services).
    - Moves outside the geographic area of ICM responsibility. In such cases, the ICM team shall arrange for transfer of Mental Health service responsibility to an ACT or ICM program or another provider wherever the beneficiary is moving. The ICM team shall maintain contact with the beneficiary until this service transfer is complete.

- Declines or refuses services and requests discharge despite the team's documented best efforts to utilize appropriate engagement techniques to develop a mutually acceptable participant-directed Recovery Plan with the beneficiary:
  - Prior to discharge from ICM services, the EEU shall approve and/or request further information to review the circumstances, clinical situation, risk factors, and attempted strategies to engage the beneficiary.

- In addition to the discharge criteria listed above, based on mutual agreement within the ICM team, a beneficiary discharge may also be facilitated due to any one (1) of the following circumstances:
  - Death.
  - Inability to locate the beneficiary despite documented active outreach efforts by the team for a period of 90 continuous days.
  - Incarceration of 90 days or more.
  - Hospitalization or Nursing Facility care where it has been determined, based on mutual agreement by the Hospital or Nursing Facility treatment team and the ICM team, with approval by the EEU, that the beneficiary will not be appropriate for discharge from the Hospital or Nursing Facility for a prolonged period of time.

Specify limits (if any) on the amount, duration, or scope of this service for (chose each that applies):

X	***Categorically needy (specify limits):***

CPST Limitations

Services are subject to prior approval, must be medically necessary, and must be recommended by a LBHP or Physician according to a Recovery Plan. The activities included in the service must be intended to achieve identified Recovery Plan goals or objectives. The Recovery 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 these specific Rehabilitative services. The Recovery Plan should identify the Medical or Remedial services intended to reduce the identified condition, as well as improve the anticipated outcomes for the beneficiary. The Recovery Plan must specify the frequency, amount, and duration of services. The Recovery Plan must be signed by the LBHP or Physician responsible for developing the plan. The Recovery 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 the Recovery Plan to determine whether services have contributed to meeting the stated goals. The beneficiary should sign the Recovery Plan. At the reevaluation, a new Recovery Plan should be developed if there is no measurable 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 case records that include a copy of the Recovery Plan, the name of the beneficiary, dates of services provided, nature, content and units of treatment and Rehabilitation services provided, and progress made toward functional improvement and goals in the Recovery Plan. Services provided at a work site must not be job task oriented and may not duplicate any services provided aimed at supporting the beneficiary in the attainment or maintenance of employment. 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, childcare, and laundry services) are non-covered. Services cannot be provided in an IMD. Room and Board is excluded. Services may be provided at a community-based site-based facility, in the community, or in the beneficiary's place of residence, as outlined in the Recovery Plan. Components that are not provided to, or directed exclusively toward the treatment of, the Medicaid-eligible beneficiary are not eligible for Medicaid reimbursement.

Beneficiaries enrolled in ACT/ACT Plus/ICM receive CPST solely through their ACT/ACT Plus/ICM team.EBPs require prior approval and fidelity reviews on an ongoing basis as determined necessary by DHSS.

Caseload size must be based on the needs of the beneficiaries/families with an emphasis on successful outcomes and beneficiary satisfaction and must meet the needs identified in the Recovery Plan. The CPST provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a LBHP with experience regarding this specialized Mental Health service.

	The Care Manager must ensure that the provider maintains documentation and that the Care Manager monitors the services on an ongoing basis to ensure that the health and welfare of the beneficiary is met, and the Recovery Plan goals are achieved. The documentation must be available to the Care Manager for monitoring at all times, on an ongoing basis. Documentation in accordance with DHSS requirements must be maintained in the beneficiary's file by the Care Manager and updated with each reauthorization, as applicable.
☐	***Medically needy (specify limits):***

Specify whether the service may be provided by a (check each that applies):	☐	Relative.
	☐	Legal Guardian.
	☐	Legally Responsible Person.

Provider Qualifications

Provider Type (Specify):	**License (Specify):**	**Certification (Specify):**	**Other Standard (Specify):**
SUD Treatment Program or a COD (SUD with mental health disorder) Treatment Program.	16 Del. Admin. C.§ 6001 et seq (Division of Substance Abuse and Mental Health [DSAMH] Substance Abuse Facility Licensing Standards).		• SUD and COD treatment programs providing CPST must employ professionals determined to be a Clinician under State regulations, meaning a person with a doctoral or master's degree in psychology, counseling, social work, nursing, rehabilitation, or related field from an accredited college or university. • Anyone providing SUD services must be certified by DHSS, in addition to any required scope of practice license required for the facility or agency to practice in the State.
ACT Team (including specialized SUD ACT team and ACT reintegration team).		Certification by DSAMH as an ACT team in fidelity with the Tool for Management of Assertive Community Treatment (TMACT).	• In compliance with TMACT fidelity (scoring at least a 3.0) or having provisional certification, ACT teams may provide any component of the services listed and must employ and utilize the qualified State Plan providers (i.e., Physicians, Licensed Practitioners) and HCBS providers necessary to maintain fidelity, including CPST specialists. • ACT team clinician must: — Be a Clinician under State regulations, meaning a person with a doctoral or master's degree in psychology, counseling, social work, nursing, rehabilitation, or related field from an accredited college or university. • Anyone providing SUD services must be certified by DHSS, in addition to any required scope of practice license required for the facility or agency to practice in the State.
ICM Team.		Certification by DSAMH in fidelity with State ICM standards.	• In compliance with State mandates under the settlement, ICM teams may provide any component of the services listed and must employ and utilize the qualified State Plan providers (i.e., Physicians, Licensed Practitioners) and HCBS providers necessary to maintain fidelity, including CPST specialists.

			ACT teams not meeting provisional certification, or having fidelity below 3.0, are ICM teams. • ICM team clinician must: — Be a Clinician under State regulations, meaning a person with a doctoral or master's degree in psychology, counseling, social work, nursing, rehabilitation, or related field from an accredited college or university. • Anyone providing SUD services must be certified by DHSS, in addition to any required scope of practice license required for the facility or agency to practice in the State.
ACT Plus Team.			• Designation by DSAMH as a qualified ACT Plus team, including compliance with minimum State training requirements and other settlement requirements. • In compliance with State mandates under the settlement, ACT Plus teams may provide any component of the services listed and must employ/contract and utilize the qualified HCBS providers necessary to maintain beneficiaries in the community, including CPST specialists. • ACT Plus team clinician must: — Be a Clinician under State regulations, meaning a person with a doctoral or master's degree in psychology, counseling, social work, nursing, rehabilitation, or related field from an accredited college or university. • Anyone providing SUD services must be certified by DHSS, in addition to any required scope of practice license required for the facility or agency to practice in the State.
PROMISE Rehabilitation Agency.			• Designation by DSAMH as a qualified PROMISE Rehabilitation Agency, including compliance with minimum State training requirements and other settlement requirements. • In compliance with State mandates under the settlement, PROMISE Rehabilitation Agencies may provide any component of the services listed and must employ/contract and utilize the qualified HCBS providers necessary to maintain beneficiaries in the community, including CPST specialists. • CPST Specialists in a PROMISE Rehabilitation Agency must: — Be a Clinician under State regulations, meaning a person with a doctoral or master's degree in psychology, counseling, social work, nursing, rehabilitation, or

			related field from an accredited college or university. • Anyone providing SUD services must be certified by DHSS, in addition to any required scope of practice license required for the facility or agency to practice in the State.

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):***
SUD Treatment Program or a COD (SUD with mental health disorder) Treatment Program.	DHSS or its designee.	Upon contracting, and at least bi-annually thereafter, DHSS will conduct and onsite audit to ensure that all providers are appropriately credentialed.
ACT Team.	DHSS or its designee.	Upon contracting, and at least bi-annually thereafter, DHSS will conduct an onsite audit to ensure that all providers are appropriately credentialed.
ICM Team.	DHSS or its designee.	Upon contracting, and at least bi-annually thereafter, DHSS will conduct an onsite audit to ensure that all providers are appropriately credentialed.
ACT Plus Team.	DHSS or its designee.	Upon contracting, and at least bi-annually thereafter, DHSS will conduct an onsite audit to ensure that all providers are appropriately credentialed.
PROMISE Rehabilitation Agency.	DHSS or its designee.	Upon contracting, and at least bi-annually thereafter, DHSS will conduct an onsite audit to ensure that all providers are appropriately credentialed.

Service Delivery Method				
Service Delivery Method (Check each that applies):	☐	Participant-directed.	X	Provider managed.

Billing Method	
Bill Code:	**Billing Rate and Unit:**
H0036: • Community psychiatric supportive treatment, face-to-face, per 15 minutes. H0036 U1: • Community psychiatric supportive treatment, face-to-face, per 15 minutes. • U1 = Medicaid level of care 1, services rendered in a home and community-based setting.	• Office: $20.64 (1:1). • Community: $22.71 (1:1).

EBP Billing

Service:	Limitations:	Bill Code:	Billing Rate and Unit:
ACT. *EBP requires fidelity.	See EBP certification guidelines for ACT/ICM limits. Practitioners on an ACT team are subject to the following billing limits per category per month per beneficiary, not to exceed a total of four (4) per diems (as defined above) per beneficiary in total from any combination of practitioners. (*Note: the billing must be based on actual services provided to the client and medically necessary care consistent with the fidelity model should be delivered, even if beyond the minimum number of units permitted to be billed under this reimbursement strategy*): • Category 1: Physicians and Advanced Practice Registered Nurses (APRNs) may not bill more than one (1) per diem for a beneficiary per month in total. • Category 2: Any combination of Psychologist, master's level, Team Leader, Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), Licensed Marriage and Family Therapist (LMFT), Licensed Associated Counselor (LAC), behavioral health other, RN, and Licensed Practical Nurse (LPN) may not bill more than two (2) per diems for a beneficiary in a month total. Ideally, this visit will not be in a clinic setting. • Category 3: All other practitioners on the ACT team may bill up to two (2) per diems for a beneficiary in a month total. Ideally, these visits will not be in a clinic setting.	H0040 HO: • ACT program, per diem. • HO – Team lead and Master's level.	H0040 HO New Team First Year Rate: • Small: $208.21. • Large: $195.91. H0040 HO Established Team Rate: • Small: $197.09. • Large: $187.15.
		H0040 HN: • ACT program, per diem. • HN – Bachelor's level.	H0040 HN New Team First Year Rate: • Small: $177.04. • Large: $165.80. H0040 HN Established Team Rate: • Small: $167.59. • Large: $158.39.
		H0040 HM: • ACT program, per diem. • HM – Less than bachelor's level.	H0040 HM New Team First Year Rate: • Small: $170.88. • Large: $159.83. H0040 HM Established Team Rate: • Small: $161.76. • Large: $152.69.
		H0040 AM: • ACT program, per diem. • AM – Physician team member.	H0040 AM New Team First Year Rate: • Small: $685.11. • Large: $658.31. H0040 AM Established Team Rate: • Small: $648.54. • Large: $628.90.
		H0040 HP: • ACT program, per diem. • HP – Nurse practitioner/APRN	H0040 HP New Team First Year Rate: • Small: $618.71. • Large: $596.96. H0040 HP Established Team Rate: • Small: $591.03. • Large: $574.76.
		H0040 TD: • ACT program, per diem. • TD – RN.	H0040 TD New Team First Year Rate: • Small: $256.54. • Large: $242.74. H0040 TD Established Team Rate: • Small: $242.85. • Large: $231.89.

		H0039 HO: • ACT program, 15 minutes. • HO – Team Lead and Master's level.	H0039 HO New Team First Year Rate: • Small: $54.25. • Large: $52.59. H0039 HO Established Team rate: • Small: $29.49. • Large: $28.53.
		H0039 HN: • ACT program, 15 minutes. • HN – Bachelor's level.	H0039 HN New Team First Year Rate: • Small: $43.97. • Large: 42.37. H0039 HN Established Team Rate: • Small: $24.29. • Large: $23.35.
		H0039 HM: • ACT program, 15 minutes. • HM – Less than bachelor's level.	H0039 HM New Team First Year Rate: • Small: $43.97. • Large: $42.37. H0039 Established Team Rate: • Small: $23.46. • Large: $22.52.
		H0039 AM: • ACT program, 15 minutes. • AM – Physician team member.	H0039 AM New Team First Year Rate: • Small: 140.42. • Large: $139.24. H0039 AM Established Team Rate: • Small: $114.00. • Large: $113.03.
		H0039 HP: • ACT program, 15 minutes. • HP – Nurse Practitioner/APRN.	H0039 HP New Team First Year Rate: • Small: $75.72. • Large: $74.54. H0039 HP Established Team Rate: • Small: $61.60. • Large: $60.74.
		H0039 TD: • ACT program, 15 minutes. • TD – RN.	H0039 TD New Team First Year Rate: • Small: $42.69. • Large: $41.51. H0039 TD Established Team Rate: • Small: $35.01 • Large: $34.04

ICM. *EBP requires fidelity.	See EBP certification guidelines forACT/ICM limits. If billing using per diems, practitionerson the ICM team are subject to the following billing limits per category per month per beneficiary not to exceed a total of six (6) per diems per beneficiary in total from any combination of practitioners. (*Note: Medically necessary care under this model should be delivered even if beyond the minimum number of units permitted to be billed under this model*): • Category 1: Physicians and APRNs may not bill more thanone (1) per diem in total for a beneficiary in a month total. • Category 2: Any combination of Psychologist, master's level, Team Leader, LCSW, LPC, LMFT, LAC, behavioral health other, RN, and LPN may not bill more than two (2) per diems for a beneficiary in a month total. • Category 3: All other practitionerson the ICM team may bill up to five (5) per diems for a beneficiary in a month total, and no more than three (3) in a clinic setting.	H0037 HO: • ICM program, per diem. • HO – Team Lead and Master's level.	H0037 HO New Team First Year Rate: • Small: $197.80. • Large: $186.11. H0037 HO Established Team Rate: • Small: $187.24. • Large: $177.80.
		H0037 HN: • ICM program, per diem. • HN – Bachelor's level.	H0037 HN New Team First Year Rate: • Small: $168.19. • Large: $157.51. H0037 HN Established Team Rate: • Small: $159.21. • Large: $150.47.
		H0037 HM: • ICM program, per diem. • HM – Less than bachelor's level.	H0037 HM New Team First Year Rate: • Small: $162.33. • Large: $151.84. H0037 HM Established Team Rate: • Small: $153.67. • Large: $145.05.
		H0037 AM: • ICM program, per diem. • AM – Physician team member.	H0037 AM New Team First Year Rate: • Small: $650.85. • Large: $625.39. H0037 AM Established Team Rate: • Small: $616.11. • Large: $597.45.
		H0037 HP: • ICM program, per diem. • HP – Nurse Practitioner/APRN.	H0037 HP New Team First Year Rate: • Small: $592.78. • Large: $572.11. H0037 HP Established Team Rate: • Small: $566.48. • Large: $551.02.
		H0037 TD: • ICM program, per diem. • TD – RN.	H0037 TD New Team First Year Rate: • Small: $243.72. • Large: $230.60. H0037 TD Established Team Rate: • Small: $230.71. • Large: $220.30.

	ICM 15-minute units may only be billed when the ICM practitioner has performed a medically necessary face-to-face service with the client or a family member for that time. Small ICM teams serve, on average, 100 or less clients. Large ICM teams serve, on average, 101–200 clients: • For an ICM team per diem to be generated, a 15-minute or longerface-to-face contact that meets all requirements outlined below must occur. A 15-minute contact is defined as lasting at least eight (8) minutes. Group contactsalone are not permitted as aface-to-face contact for generating an ICM per diem rate. • ICM practitioners using a 15-minute unit rate, may only bill for a 15-minute unit if at least eight (8) minutes of service is provided. • Group ICM contacts are not reimbursable. • Practitioners may not bill for services included in the ICM per diem or 15-minute units and also bill for that service outside of the per diem/15-minute rate for consumers enrolled in ICM. • Effective July 1, 2014, all services require prior authorizations.	H0036 HO: • ICM program, 15 minutes. • HO – Team Lead and Master's Level.	H0036 HO New Team First Year Rate: • Small: $35.42. • Large: $35.10. H0036 HO Established Team Rate: • Small: $30.25. • Large: $29.93.
		H0036 HN: • ICM program, 15 minutes. • HN – Bachelor's level.	H0036 HN New Team First Year Rate: • Small: $28.54. • Large: $28.22. H0036 HN Established Team Rate: • Small: $24.47. • Large: $24.15.
		H0036 AM: • ICM program, 15 minutes. • AM – Physician team member.	H0036 AM New Team First Year Rate: • Small: $73.81. • Large: $73.63. H0036 AM Established Team Rate: • Small: $60.49. • Large: $60.31.
		H0036 HM: • ICM program, 15 minutes. • HM – Less than bachelor's level.	H0036 HM New Team First Year Rate: • Small: $28.54. • Large: $28.22. H0036 HM Established Team Rate: • Small: $24.47. • Large: $24.15.
		H0036 HP: • ICM program, 15 minutes. • HP – Nurse Practitioner/APRN.	H0036 HP New Team First Year Rate: • Small: $38.60. • Large: $38.42. H0036 HP Established Team Rate: • Small: $31.72. • Large: $31.54.
		H0036 TD: • ICM program, 15 minutes. • TD – RN.	H0036 TD New Team First Year Rate: • Small: $22.42. • Large: $22.23. H0036 TD Established Team Rate: • Small: $18.51. • Large: $18.31.

Community Transition Services

Service Specification	
Service Title:	Community Transition Services
Service Definition (Scope):	
Community Transition Services are non-recurring set-up expenses for beneficiaries who are transitioning from an Institutional or another provider-operated living arrangement to a living arrangement where the person has a lease (e.g., apartment) or is in a private residence. The beneficiary is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute Room and Board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the beneficiary's health and safety, such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) necessary home accessibility adaptations; and, (g) activities to assess need, arrange for, and procure needed resources. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the Recovery Plan development process; clearly identified in the Recovery Plan; the person is unable to meet such expense; or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes. Community Transition Services may not include payment for Room and Board. The payment of a security deposit is not considered rent. When Community Transition Services are furnished to beneficiaries returning to the community from a Medicaid institutional setting through entrance to the waiver, the costs of such services are considered to be incurred and billable when the person leaves the institutional setting and enters PROMISE. The beneficiary must be reasonably expected to be eligible for and to enroll in the waiver. If, for any unseen reason, the beneficiary does not enroll in the waiver (e.g., due to death or a significant change in condition), Transitional services may be billed to Medicaid as an administrative cost. Community Transition Services may be furnished as a PROMISE service to beneficiaries who transition from provider-operated settings other than Medicaid reimbursable institutions to their own private residence in the community. Community Transition Services may not be used to pay for furnishing living arrangements that are owned or leased by a PROMISE provider, where the provision of these items and services are inherent to the service they are already providing.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Community Transition Services are limited to $1,800 per person but may be exceeded on a case-by-case basis with prior authorization, based on medical necessity.	
Additional medical necessity criteria for receiving the service, if applicable (specify):	
To be authorized as a PROMISE service on a Recovery Plan, the following authorization criteria must be met at a minimum: • The service is recommended by the Care Manager and the beneficiary in collaboration, and the service is included in the beneficiary's Recovery Plan, AND • Requests for home accessibility adaptations align with the unique needs of the beneficiary (e.g., beneficiary with hearing impairment needs additional alerting systems for doorbells and smoke alarms; beneficiary with a wheelchair needs a ramp leading to the front door). • The service is directly related to a goal on the beneficiary's Recovery Plan related to transitioning from an institutional or other provider-operated living arrangement to a living arrangement where the beneficiary has a lease (e.g., apartment) or is in a private residence, AND • The beneficiary is unable to meet such expense or obtain needed support from other sources (i.e., other sources have been exhausted first), AND • The service will not be used for monthly rental or mortgage expenses, Room and Board, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes, AND • The beneficiary has not received this service previously for transition to this setting.	

Provider Specifications				
Provider Category(s) (check one or both):	☐	Individual (list types):	☐	Agency (list types):
				Housing Agency
Specify whether the service may be provided by (check each that applies):	☐	Legally Responsible Person.	☐	Relative/Legal Guardian.

Provider Qualifications			
Provider Type:	**License (specify):**	**Certificate (specify):**	**Other Standard (specify):**
Housing Agency			Meeting DSAMH requirements for a Housing Agency. • Comply with State regulations and policies, and have a provider agreement. • Comply with DHSS standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. • Have Worker's Compensation insurance in accordance with State statute and in accordance with DHSS policies. • Have Commercial General Liability insurance. • Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet the unique needs of the beneficiary (e.g., communication, mobility, and behavioral needs). • Meet all local and State requirements for the service. All items and services shall be provided according to applicable State and local standards of manufacture, design, and installation. • Individuals working for or contracted with an agency must: – Be at least 18 years of age. – Comply with DHSS standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. – Complete DHSS-required training, including training on the beneficiary's Recovery Plan and the beneficiary's unique needs, which may include, but are not limited to, communication, mobility, and behavioral needs. – Have a valid driver's license if the operation of a vehicle is necessary to provide the service.

Verification of Provider Qualifications:		
Provider Type:	***Entity Responsible for Verification:***	***Frequency of Verification:***

Housing Agency	DHSS or its designee.	— Upon contracting, and at least bi-annually thereafter, DHSS will ensure that the Housing Agencies under contract meet requirements.

Service Delivery Method				
Service Delivery Method (check each that applies):	☐	Participant-directed.	☐	Provider managed.

Billing Method	
Bill Code:	**Billing Rate and Unit:**
T2028: • Specialized supply, not otherwise specified (NOS), waiver.	Market rate.
T2035: • Utility services to support medical equipment and assistive technology/devices, waiver.	Market rate.
T2038: • Community transition, waiver, per service.	Market rate.

Community-based Residential Alternatives Excluding Assisted Living (Residential Alternatives)

Service Specification	
Service Title:	Community-based Residential Alternatives Excluding Assisted Living (Residential Alternatives)

Service Definition (Scope):

Community-based Residential Alternatives (excluding Assisted Living) offer a cost-effective, community-based alternative to Nursing Facility care for persons with behavioral health needs. Community-based Residential services are supportive and health-related Residential services provided to beneficiaries in settings licensed by the State. Residential services are necessary, as specified in the Recovery Plan, to enable the beneficiary to remain integrated in the community and ensure the health, welfare, and safety of the beneficiary. Community-based Residential services include Personal Care and Supportive services (Homemaker, Chore, Attendant services, and Meal Preparation) that are furnished to beneficiaries who reside in home-like, non-institutional, integrated settings. In addition, 24-hour on site response capability to meet scheduled and unscheduled or unpredictable beneficiary needs and to provide supervision and safety. Services also include social and recreational programming, and medication assistance (to the extent permitted under State law).

This service includes assisting beneficiaries in acquiring, retaining, and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources, and adaptive skills necessary to reside successfully in home and community-based settings. As needed, this service may also include prompting to carry out desired behaviors and/or to curtail inappropriate behaviors, as well as Habilitative services to instruct beneficiaries in accessing and using community resources such as transportation, translation, and communication assistance related to a Habilitative outcome, and services to assist the beneficiary in shopping and other necessary activities of community and civic life, including self-advocacy. Finally, assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) are included. This service will be provided to meet the beneficiary's needs as determined by an assessment performed in accordance with DHSS requirements and as outlined in the beneficiary's Recovery Plan.

ADLs include tasks related to caring for and moving the body:

- Walking.
- Bathing.
- Dressing.
- Toileting.
- Brushing teeth.
- Eating.

IADLs are the activities not directly related to functional activities; rather, they are assistance with an additional set of more complex life functions necessary for maintaining a person's immediate environment and living independently in the community. IADLs include:

- Cooking and meal planning.
- Performing ordinary housework.
- Getting around in the community.
- Using the telephone or computer.
- Shopping for groceries.
- Supporting the beneficiary in exploring employment opportunities.
- Keeping track of finances.
- Managing medication including assisting with setting up medication administration mechanisms (e.g., pill jars) and ensuring that beneficiaries have the supports necessary to timely take medications. (Not appropriate for Peer Specialists.)

If there is more than one (1) staff member on site at the residence during normal hours who can provide Personal Care services, the provider will be encouraged to hire staff to deliver Personal Care services separate from staff who provide Habilitation services that involve the development of ADL and IADL skills. This will ensure that the clinical boundary issues that would otherwise complicate Habilitation services (if the same staff were also delivering Personal Care services) will be mitigated.

Services must be delivered in a manner that supports the beneficiary's communication needs including, but not limited to, age-appropriate communication, translation/Interpretation services for beneficiaries that are of limited English proficiency, or who have other communication needs requiring translation, and assistance with the provider's understanding and use of communication devices used by the beneficiary.

The cost of transportation provided by Residential service providers to and from activities is included as a component of the Residential services and, therefore, is reflected in the rate for the service. Providers of Residential services are responsible for the full range of Transportation services needed by the beneficiaries they serve to participate in services and activities specified in their Recovery Plan. This includes transportation to and from day activities and Employment services, as applicable.

The following levels of Residential services are available to beneficiaries as determined necessary, based upon a quarterly assessment, documented in the Recovery Plan, and approved by DHSS.

Note: prior to be eligible for Tier 1, the beneficiary is considered to be in Tier 0 and eligible to receive any PROMISE services other than Community-based Residential Alternatives.

Tier 0 — Private Housing or Transitional Housing (not eligible for Community-based Residential Alternatives/Residential Alternatives)

For this tier, a beneficiary may be in private non-supported housing, in transitional housing with a State Rental Assistance Program (SRAP) voucher awaiting location of permanent housing, or in permanent housing with a SRAP voucher. Housing assistance, if offered, is State or federally funded. Room and Board is not Medicaid funded and is outside of Residential Alternatives. This tier equates to the current transitional housing or SRAP voucher program. All PROMISE services on a beneficiary's Recovery Plan are provided by community providers.

Model 1 — Habilitative Supports in the Home (the Beneficiary is Encouraged to seek Behavioral Health Treatment for SPMI in the Community) (Tiers 1 and 2)

Tier 1

The goal should be to move to independent living, by reducing the need for ADL and IADL assistance, while considering social needs and the resulting proper timing of move to independent living. Residential staff should be part of the clinical team — in recovery planning, etc. This tier is not available in a Group Home. The beneficiary's PROMISE Recovery Plan indicates when Residential Alternatives staff assist with ADLs (and IADLs).

A beneficiary requires:

- Limited supervision as the beneficiary is able to make safe decisions when in familiar surroundings, but requires occasional increased need for assistance or to address unanticipated needs, with supports available on a 24-hour on call or as-needed basis, AND
- Incidental or intermittent hands-on assistance or cueing for at least one (1) ADL and at least one (1) IADL, OR
- Incidental or intermittent hands-on assistance or cueing with at least three (3) IADLs, OR
- Instruction in accessing and using community resources such as transportation, translation, and communication assistance related to a Habilitative outcome, and services to assist the beneficiary in shopping and other necessary activities of community and civic life, including self-advocacy, OR
- Instruction in developing or maintaining financial stability and security (e.g., understanding budgets, managing money, and the right to manage their own money).
- Tier 1 Community-based Residential Alternatives services are provided in a Supervised Apartment setting up to 18 months by a Supportive Housing Agency complying with the following staffing ratios for 6–10 beneficiaries not in ACT/ICM. One (1) staff is on site during business hours to assist with ADLs. The staff has a high school degree. A high school level staff person is on call for evening and weekend back-up. *On-call staff do not sleep overnight. A total of 4.25 FTE, including .25 FTE of a Residence Manager/Supervisor's time is assumed in the rates. Note: Staff on clinical teams (e.g., co-occurring

clinic staff) provide Community-based Behavioral Health Treatment/Rehabilitation and consult to site staff. Community-based Residential Alternatives services are not available to beneficiaries on an ACT/ICM team assessed at Tier 1. If the beneficiary is on an ACT/ICM team, the ACT/ICM teams provides all Day services, the Community-based Residential Alternatives provider does not provide Day Support. In addition, the ACT/ICM team provides Night Support. The ACT/ICM provides on call staff for evening and weekend back-up. On-call staff do not sleep overnight.

Medical Necessity Criteria for Tier 1

American Society of Addiction Medicine (ASAM) Criteria

- Low immediate need on ASAM:

  Dimension 1. Substance Abuse: adequate ability (second choice).

  Dimension 2. Biomedical: no known or stable.

  Dimension 3. Suicidality: can have up to "has frequent thoughts" (#2).

  Dimension 3. Suicidality: Control/Impulsivity — low.

  Dimension 3. Dangerousness: can have history, but not current.

  Dimension 3. Self-care: requires assistance in personal care, life skills — must assess number of ADLs/IADLsneeded and must meet PROMISE service description criteria.

Independent Living Inquiry

- Assess ADL/IADL need.
- Initial assistance for one (1) ADL and one (1) IADL, but continuing assistance/monitoring not needed OR initial assistance for three (3) IADLs*, but continuing assistance/monitoring not needed.

Community Living Questionnaire

- Person's preference (Q2) helps determine Tier 1 versus independent living.

**The number of ADLs and IADLs listed here provides a general guide. A person who has more difficulty with ADLs and IADLs than represented here, but who has natural supports available to provide regular, consistent assistance, might be able to be served at this tier rather than at a higher tier. On the other hand, a person with the same number of ADLs and IADLs in question might need a higher (or lower) tier, depending on the severity of his or her needs.*

Tier 2

For this tier, the goal should be to move to Tier 1 (or straight to independent living, if need is four (4) IADLs) by reducing the need for continuing ADL assistance, while considering social needs and the resulting proper timing of moving to new residence; residential staff should be part of the clinical team — in recovery planning, etc. This tier is not available in a Group Home. In order to ensure that beneficiaries have a choice of Day services, beneficiaries on ACT/ICM teams will be served by the ACT/ICM team during the day. Tier 2 beneficiaries on ACT/ICM teams may choose to receive Night services from the Community-based Residential Alternatives providers. If a beneficiary chooses to not receive ACT/ICM or is not eligible for ACT/ICM, he or she may receive Community-based Residential Alternatives during the day and/or night, as necessary to promote recovery and as outlined on the Recovery Plan. This service is provided in Supervised Apartments up to 18 months.

A beneficiary requires:

- Low intensity supervision with staff on site or available to ensure safety from harm as determined by an assessment, OR
- Provision of care by an Unlicensed Practitioner depending on the assessment and the Recovery Plan, AND
- Management of one (1) or more behaviors that prevent or interfere with the beneficiary’s inclusion in home and family life or community life, OR
- Hands-on assistance or cueing for at least two (2) ADLs, OR
- Hands-on assistance or cueing with at least four (4) IADLs, OR
- Instruction in accessing and using community resources such as transportation, translation, and communication assistance related to a Habilitative outcome and services to assist the beneficiary in shopping and other necessary activities of community and civic life, including self-advocacy, OR
- Instruction in developing or maintaining financial stability and security (e.g., understanding budgets, managing money, and the right to manage their own money).

Tier 2 — Staffing for Beneficiaries Not in ACT/ICM for 6–10 Residents

Day Community-based Residential Alternatives rate — 3.0 full-time equivalent (FTE) spread during the two-day shifts during the week and weekend per 6–10 residents; the rates assume 2.75 FTE of a high school level person trained to assist with ADLs and 0.25 FTE of a Residence Manager/Supervisor. Staff on clinical teams (e.g., co-occurring clinic staff) provide Community-based Behavioral Health Treatment/Rehabilitation and consult to site staff.

Night Community-based Residential Alternatives rate — 2.0 FTE spread over the night week and weekend night shifts who are on call and are within walking distance throughout the night shift; staff do not sleep overnight. 0.25 FTE of a Residence Manager/Supervisor also on staff. Staff on clinical teams (e.g., co-occurring clinic staff) provide Community-based Behavioral Health Treatment/Rehabilitation and consult to site staff.

Tier 2 — Staffing for Beneficiaries in ACT/ICM for 6–10 Residents

The ACT/ICM team provides daily support. ACT/ICM provides all Day services; the Community-based Residential Alternatives provider does not provide Day Supports.

Receive Only the Night Community-based Residential Alternatives rate — Clinical staff are on call from ACT/ICM team and provide Community-based Behavioral Health Treatment/Rehabilitation and consult to site staff.

Medical Necessity Criteria for Tier 2

ASAM Criteria

- Low immediate need on ASAM:
  - Dimension 1. Substance Abuse: can have “some difficulty” (third choice in the list of potential statuses).
  - Dimension 2. Biomedical: no known or stable.
  - Dimension 3. Suicidality: can have up to "has frequent" (#2).
  - Dimension 3. Suicidality: control/impulsivity — low.
  - Dimension 3. Dangerousness: can have history, but not current.
  - Dimension 3. Self-care: requires assistance in personal care, life skills — must assess number of ADLs/IADLsneeded and must meet PROMISE service description criteria.
  - Dimension 3. Psychological/Emotional Health: any level.
  - Dimension 4. Readiness to Change: any level but does participate in treatment in community.
  - Dimension 5. Relapse, etc.: all but fourth choice ("not taking prescribed medications...").

Independent Living Inquiry

- Initial or continual assistance for two (2) ADLs OR initial or continual assistance with four (4) IADLs is needed*.

Community Living Questionnaire

- Person’s preference (Q2) — helps in goal setting, recovery planning, and assessment.

**The number of ADLs and IADLs listed here provides a general guide. A person who has more difficulty with ADLs and IADLs than represented here, but who has natural supports available to provide regular, consistent assistance, might be able to be served at this tier rather than at a higher tier. On the other hand, a person with the same number of ADLs and IADLs in question might need a higher (or lower) tier, depending on the severity of his or her needs.*

Model 2 — Intensive Supports for Medically Fragile Beneficiaries (Tiers 3 and 4)

Tier 3

For this tier, the goal could be to remain in Group Home versus Nursing Home, as long as possible, or to move to Tier 2 if biomedical need is not permanent. This tier could be in a Supervised Apartment or Group Home. Beneficiaries on ACT teams may not be in Group Homes at this tier and should be transitioned off the ACT team immediately. *Tier 3 is for people with medically fragile beneficiaries at least one (1) staff person during regular business hours should be a nurse. This tier focuses on people with medical needs. Beneficiaries in this level of Community-based Residential Alternatives have medical needs that prohibit their residing more independently. The staff person who is covering in the evenings should have the basic capacity to deal with medical issues that arise. In this tier, the Group home is expected to meet all physical needs of the client within the rate provided. This tier is not eligible for PLUS LTC (i.e., not eligible for

Nursing Facility level of care). Group Home or Supervised Apartment: short-term to long-term, depending on acute versus chronic.

A beneficiary requires:

- Supervision with staff on site to ensure safety from harm as determined by an assessment.
- Intermittent skilled care of a Licensed Professional or Paraprofessional throughout the day for medical diagnosis or medical treatment.
- Management of one (1) or more behaviors of a disruptive or destructive nature that prevent or interfere with the beneficiary's inclusion in home and family life or community life, AND/OR
- Hands-on assistance or cueing with at least two (2) ADLs or periodic assistance throughout a day with at least three (3) ADLs, OR
- Complete assistance with at least four (4) IADLs.

Medical Necessity Criteria for Tier 3

ASAM Criteria

- High biomedical immediate need:
  1. Substance Abuse: can have some difference or past history (third and fourth choices).
  2. Biomedical: "current/unstable".
  3. Suicidality: any level, but doesn't need acute.
  3. Suicidality: control/impulsivity — moderate to high.
  3. Dangerousness: can have moderate–high risk.
  3. Self-care: any level, but will tend to not seek treatment without assistance, and require assistance in personal care, life skills (see PROMISE service descriptions), or other ASAM items checked.
  3. Psychological/Emotional Health: any level.
  4. Readiness to Change: any level.
  5. Relapse, etc.: any level.

Independent Living Inquiry — Special Attention to Biomedical Need

- Hands-on assistance or cueing with at least two (2) ADLs or periodic assistance throughout a day with at least three (3) ADLs, or complete assistance with at least four (4) IADLs.

Community Living Questionnaire

- Person's preference (Q2) — helps in goal setting, recovery planning, and assessment.

Tier 3 Staffing — Supervised Apartment

At the highest level (Tier 2) with beneficiary supports from outside providers on the Recovery Plan to address individual assessed needs. The total cost of CPST, PSR, Habilitation, Nursing, and Personal Care (including supports by an ACT/ACT Plus/ICM team) on the Recovery Plan may not to exceed the cost of supports in a Tier 3 Group Home. Beneficiaries in a Group Home may not receive ACT/ICM so ACT/ICM costs for a beneficiary in Supervised Apartments will be counted as supports in this model.

Tier 3 Staffing — Beneficiaries in a Group Home

The service provider shall maintain the following staffing pattern:

- For Group Homes up to five (5) residents, the rates support 7.58 FTE, including 2.0 FTE for Certified Nursing Assistants (CNAs) and 5.58 FTE for Clinicians (1.0 FTE Residence Manager, 0.08 FTE Psychiatrist, 3.0 FTE bachelor's level, 0.5 RNs, 0.4 LPNs).
- For Group Homes from 6–10 residents, the rates support 11.9 FTE, including 3.0 FTE for CNAs and 8.9 FTE for Clinicians (1.0 FTE Residence Manager, 0.15 FTE Psychiatrist, 5.0 FTE bachelor's level, 1.0 RNs, 0.4 LPNs).
- Regulations require:
  - Residence Manager who is a Clinician.
  - Psychiatrist.
  - Clinicians (PhD, master's level, RN with certification in mental health, or bachelor's level + five (5) years mental health and two (2) years residential).
  - Associate Clinicians (bachelor's level or RN).
  - Residential Service Assistant (high school diploma or equivalent).
- 75% of staff are Clinicians or Associate Clinicians.

- Between the hours of 8 AM and 10 PM: A minimum of one (1) Clinician or Associate Clinician, with sufficient training to assist residents with routine medical needs, including the administrations of medications, and to conduct basic assessment of the need for urgent, emergent or acute medical services, shall be on duty and on site for every one (1) to five (5) residents present in the home and a minimum of two (2) staff members, at least one (1) of whom shall be a Clinician, Associate Clinician, or Residential Service Assistant shall be on duty and on site whenever six (6) or more residents are present in the home.
- At all other times, a minimum of one (1) Clinician or Associate Clinician shall be on duty and on site whenever any residents are present in the home.
- At all times, at least one (1) Clinician, Associate Clinician, or Residential Service Assistant shall be available on call. When a staff member is on duty and on site alone, the on-call person must be a Clinician or Associate Clinician.
- DHSS may require a modified staffing pattern based on extenuating circumstances or resident need.
- The Psychiatrist shall visit the Group Home at least once a week and spend a minimum of one-half hour per resident per month providing direct services to residents on site, participating in the assessment of residents' needs, planning service provision, and providing supervision/consultation to other program staff. The Psychiatrist shall evaluate each resident's medications at least every two (2) weeks.
- A RN or LPN may administer medications, including injections. Residents shall take medications under direct supervision of a qualified staff member per treatment plan.
- The service provider shall designate a Clinician or Associate Clinician to be the Primary Clinician. Each beneficiary will have a treatment plan developed by the Group Home within 30 days of admission and updated every six (6) months. The beneficiaries will have a complete physical examination by a Physician within 30 days of admission unless they have had one (1) within a year of admission and their medical records are available. Each beneficiary will have an annual physical exam arranged by the Group Home. The service provider will arrange for transportation to dental evaluations (annually) and preventive care.
- If there is not an RN on staff, the Group Home shall train staff to ensure that one (1) or more members on duty has knowledge of first aid, including CPR and other care.
- DHSS may require a modified staffing pattern based on extenuating circumstances or resident need.

Tier 3 Additions

- No additional reimbursement will be granted for residents without written exception of the DSAMH fiscal officer that the reimbursement is not duplicative of the per diem rates.
- One (1) Nurse on duty at least eight (8) hours a day at primary times when medications are dispensed (breakfast and dinner). An RN is on call at all other times.
- Except as permitted in accordance with requirements contained in DHSS 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. This service may not be included on the same Recovery Plan as the following services: Nursing, Home Health Aide, Personal Care, IADL/Chore, Non-medical Transportation (NMT), or Respite.

Tier 4 — Special Care Unit Services

For this tier, the goal is to move to any Tier 1 or 2 or independent living, depending on dangerousness risk issues. This tier could be in a Supervised Apartment or Group Home. Beneficiaries on ACT teams may not be in Group Homes at this tier and should be transitioned off the ACT team immediately. Tier 4 is for people who are dangerous, so this tier should be staffed with second Clinician when there are more than five (5) clients in the home; training should highlight the risk assessment and interventions for handling dangerousness, etc. This tier is not eligible for PLUS LTC (i.e., not Nursing Facility eligible).

A beneficiary requires:

- Extensive support and cannot be left alone for any period throughout the day, as determined by an assessment or clinical determination of need for continuous supervision, due to a significant risk for recent or ongoing occurrences of behavior in which the beneficiary is a threat to self or others.

Medical Necessity Criteria for Tier 4

<u>ASAM Criteria</u>

- Can have high immediate need profile:

Dimension 1. Substance Abuse: can have current potential (fifth choice).

Dimension 2. Biomedical: up to "current/unstable".

Dimension 3. Suicidality: any level not needing acute.

Dimension 3. Suicidality: control/impulsivity — has moderate–high risk for problems.

Dimension 3. Dangerousness: highest risk that does not require inpatient.

Dimension 3. Self-care: any level, but will tend to not seek treatment without assistance, and require assistance inpersonal care, life skills (see PROMISE service descriptions), or other ASAM items checked.

Dimension 3. Psychological/Emotional Health: any level.
Dimension 4. Readiness to Change: any level.
Dimension 5. Relapse, etc.: any level (except for those in 3 to 5-day beds, which will probably have high need on 3 and on 5).

Independent Living Inquiry Special Attention to Biomedical Need

- Hands-on assistance or cueing with at least two (2) ADLs or periodic assistance throughout a day with at least three (3) ADLs, or complete assistance with at least four (4) IADLs.

Community Living Questionnaire

- Person's preference (Q2) — helps in goal setting, recovery planning, and assessment.
- ASAM, along with collaterals/health record, are important for determining Tier 4.

Tier 4 — Staffing in Supervised Apartment

At the highest level (Tier 2) with beneficiary supports on the Recovery Plan to address individual assessed needs. The total cost of CPST, PSR, Habilitation, Nursing, and Personal Care (including supports by an ACT/ACT Plus/ICM team) on the Recovery Plan may not to exceed the cost of supports in a Tier 4 Group Home. Beneficiaries in a Group Home may not receive ACT/ICM so ACT/ICM costs for a beneficiary in Supervised Apartments will be counted as supports in this model.* Clients must be on clinical teams (e.g., ACT or ICM) that can provide 24-hour back-up to on-site staff. The ACT/ACT Plus/ICM team provides all Dayservices — the Community-based Residential Alternatives provider does not provide Day Supports. All staff must be trained in and have demonstrated competence in managing dangerousness.

Tier 4 — Staffing in Group Home (Note: A Tier 4 resident is weighted at 1.25 of a Tier 3 resident)

The service provider shall maintain the following staffing pattern:

Rates are set to support the following staffing:

- For Group Homes up to five (5) residents, the rates support 9.58 FTE, including 2.5 FTE for CNAs and 7.08 FTE for Clinicians (1.0 FTE Residence Manager, 0.08 FTE Psychiatrist, 4.5 FTE bachelor's level, 0.5 RNs, 0.4 LPNs).
- For Group Homes from 6–10 residents, the rates support 11.9 FTE, including 3.0 FTE for CNAs and 8.9 FTE for Clinicians (1.0 FTE Residence Manager, 0.15 FTE Psychiatrist, 5.0 FTE bachelor's level, 1.0 RNs, 0.4 LPNs).
- Regulations require:
  - Residence Manager who is a Clinician.
  - Psychiatrist.
  - Clinicians (PhD, master's level, RN with certification in mental health, or bachelor's level + five (5) years mental health and two (2) years residential).
  - Associate Clinicians (bachelor's level or RN).
  - Residential Service Assistant (high school diploma or equivalent).
- 75% of staff are Clinicians or Associate Clinicians.
- Between the hours of 8 AM and 10 PM: A minimum of one (1) Clinician or Associate Clinician, with sufficient training to assist residents with routine medical needs, including the administrations of medications, and to conduct basic assessment of the need for urgent, emergent, or acute medical services, shall be on duty and on site for every one (1) to five (5) residents present in the home and a minimum of two (2) staff members, at least one (1) of whom shall be a Clinician, Associate Clinician, or Residential Service Assistant shall be on duty and on site whenever six (6) or more residents are present in the home.
- At all other times, a minimum of one (1) Clinician or Associate Clinician shall be on duty and on site whenever any residents are present in the home.

- At all times, at least one (1) Clinician, Associate Clinician, or Residential Service Assistant shall be available on call. When a staff member is on duty and on site alone, the on-call person must be a Clinician or Associate Clinician.
- DHSS may require a modified staffing pattern based on extenuating circumstances or resident need.
- The Psychiatrist shall visit the Group Home at least once a week and spend a minimum of one-half hour per resident per month providing direct services to residents on site, participating in the assessment of residents' needs, planning service provision, and providing supervision/consultation to other program staff. The Psychiatrist shall evaluate each resident's medications at least every two (2) weeks.
- A RN or LPN may administer medications, including injections. Residents shall take medications under direct supervision of a qualified staff member per treatment plan.
- The service provider shall designate a Clinician or Associate Clinician to be the Primary Clinician. Each beneficiary will have a treatment plan developed by the Group Home within 30 days of admission and updated every six (6) months. The beneficiaries will have a complete physical examination by a Physician within 30 days of admission, unless they have had one (1) within a year of admission and their medical records are available. Each beneficiary will have an annual physical exam arranged by the Group Home. The service provider will arrange for transportation to dental evaluations (annually) and preventive care.
- If there is not an RN on staff, the Group Home shall train staff to ensure that one (1) or more members on duty has knowledge of first aid, including CPR and other care.
- DHSS may require a modified staffing pattern based on extenuating circumstances or beneficiary need.
- No additional reimbursement will be granted for beneficiaries without written exception of the DSAMH fiscal officer that the reimbursement is not duplicative of the per diem rates. Except as permitted in accordance with requirements contained in DHSS 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. This service may not be included on the same Recovery Plan as the following services: Nursing, Home Health Aide, Personal Care, IADLs/Chore, NMT, or Respite.
- An RN is on call at all times there is not an RN/Physician on duty.

Tier 5 — Meet a Nursing Facility Level of Care and Beneficiary is in PROMISE and PLUS LTC

PLUS Long-term Care MCO Manager and the PROMISE Care Manager will develop a combined PLUS service care plan and PROMISE Recovery Plan with the beneficiary to meet extraordinary physical needs. PLUS LTC can reimburse for extraordinary needs. Tier 5 beneficiaries are eligible for Nursing Facility level of care. PROMISE pays the Tier 4 rate and then the PLUS LTC develops a PLUS service care plan under the PLUS LTC program to provide additional supports under the PLUS program necessary to maintain a beneficiary meeting the Nursing Facility level of care outside of the Nursing Facility.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Additional medical necessity criteria for receiving the service, if applicable (specify):

In addition to the medical necessity criteria outlined within each tier above, the following are criteria for determining medical necessity for Community-based Residential Alternatives

In assessing the beneficiary's need for Community-based Residential Alternatives, the Care Manager needs to use careful clinical/functional assessment, in combination with consideration of preferences and the recovery environment, in order to identify the appropriate levels and types of care. At a minimum, the following factors need to be considered in combination:

- The beneficiary's preferences for housing: The beneficiary's preferences need to be considered when identifying the appropriate levels and types of Residential support. Sometimes, the beneficiary may prefer a housing option (e.g., apartment) at a level of care that clinical and housing experts believe would create a health and safety risk, (i.e., where the person's needed level of care is higher than the preferred housing option). If this occurs, the Care Manager and beneficiary should complete a risk assessment as outlined in the Care Manager manual and the recovery plan should identify the services, activities, and supports that can be mobilized in order to achieve the beneficiary's preference. Note: Group Home rates for beneficiaries at Tier 1 and Tier 2 will not be created and reimbursement is not expected to continue for facilities when it is not medically necessary for the beneficiary to be in that environment. In cases where the beneficiary prefers a higher level of care than others believe the

beneficiary needs, the beneficiary should be encouraged to find other ways of meeting needs (e.g., for socialization) that are addressed by the higher level of care. The beneficiary Recovery Plan should provide an explicit, detailed plan for addressing those issues as well as the transition plan with deadlines and outcomes for the beneficiary to move to the appropriate housing option (e.g., from Group Home to apartment in a timely manner).

- The natural supports or environment in which the beneficiary is recovering: Residential Alternatives should not supplant natural supports. Some beneficiaries whose individual capacities alone might indicate a higher level of care should receive lower Residential Support tiers because natural supports are available to ensure the beneficiary's success in housing options at a lower level of care tier. For example, a beneficiary might have several IADLs that indicate a need for Tier 2, but she has family members and/or friends who are available on a regular basis to help her achieve those IADLs. This beneficiary might be placed in Tier 1 or even Tier 0. Landlords also are an important part of the recovery environment, and some landlords are more flexible than others in tolerating the challenges and limitations beneficiaries sometimes bring to the Residential setting.
- The beneficiary's abilities and limitations related to living in the community. The severity of any functional limitation related to an ADL or IADL should be incorporated. Two beneficiaries may both be identified as having a need for assistance with personal hygiene, but one beneficiary's inability might represent a significant health risk, while the other beneficiary's inability might merely represent an occasional risk to the quality of interactions with people who do not know the person very well. The severity of functional limitation may not just rely on the beneficiary's own self-report concerning her or his abilities and limitations in community living. It is important to bolster self-reports with the observations of collaterals (family members and other people in the beneficiary's natural support network, as well as providers who know the beneficiary well). Every beneficiary's self-report (not just the self-report of someone coping with a SMI) is limited, and it is always the case that observations of other people who know us well help round out an assessment. Sometimes, direct observations of behaviors that are associated with successful community living will also be important in establishing an accurate assessment.
- Back-Up Plans: Residential supports should not be used as substitutes for an effective back-up plan. ACT and ICM teams should provide 24/7 on-call services. Beneficiaries on ACT teams are able to live more independently than they would otherwise be able to live, due to the regular assistance of the ACT teams in providing training and support for independent living. It is assumed that all beneficiaries with Tier 1 needs on an ACT/ICM team will not receive Community-based Residential Alternatives (i.e., effectively Tier 0). Beneficiary Recovery Plans must include provisions for ensuring the beneficiary's success in community living, in case the original or initial plan needs to be revised. For beneficiaries in Tier 2 receiving ACT, who are in Supervised Apartments, there may be staff at the residence who will provide Community-based Residential Alternatives during off hours. For example, if a beneficiary's plan in the area of Community-based Residential Alternatives is contingent, in part, on the availability of a family member or other person from the natural support system to assist with certain behaviors, and that person is not available for a period of time, a "back-up plan" needs to be in place to ensure there is not significant disruption in the beneficiary's living situation. Part of the "back-up plan" could include specific activities or interventions aimed at helping bolster the beneficiary's own abilities in the area of independent living. Family members, friends, residential neighbors, companions from faith communities and other voluntary organizations, and peers from mutual/self-help organizations represent examples of natural supports that might be identified and mobilized to ensure that any Residential support needs are met during off hours.
- All beneficiaries in Tiers 1–4 Community-based Residential Alternatives have SMI.
- Tier 0 is for beneficiaries with SRAP vouchers who only need temporary housing. No Community-based Residential Alternatives are provided.
- Tiers 1–2 are for beneficiaries NOT high on an ASAM Immediate Need profile.
- Tier 2-A is to be utilized for beneficiaries who have not yet been assessed for PROMISE, but are referred because they are presumed to be eligible for PROMISE. Beneficiaries should be assessed by Care Managers for PROMISE prior to leaving State Hospitals. These are considered emergency placements only. Tier 2-A = Resource beds: 1–3 months. A = Assessment. Goal is for Care Manager to assess beneficiary, develop Recovery Plan, and assist the beneficiary with implementing more permanent services within 1–3 months. Note: Care Manager should have assessment and Recovery Plan completed within 30 days of referral to program, and Recovery Plan should be implemented within 45 days of Recovery plan approved by EEU.

- Tiers 3–4 include some people high on ASAM Immediate Need profile.
- ASAM Dimension 3 (self-care, dangerousness, etc.) must be used in conjunction with health record review and interview with collaterals (e.g., providers) to assess specific level of risk (e.g., number of ADLs/IADLs) the beneficiary needs assistance with, and dangerousness (to assess need for Tier 4):
  - ASAM is important for determining need for Tier 4 (with dangerousness being the most important dimension for consideration).
  - In combination with the Community Living Questionnaire and data from collaterals/health record, ASAM is helpful in determining need for Tier 3, based on biomedical need.
- Community Living Questionnaire should not only help with placement, but should aid in individualized Community-based Residential Alternatives planning for all four (4) tiers and should help provide prognosis for length of stay (which can vary considerable within tiers):
  - Independent Living with in-home supports versus Tier 1 Group Home placement — based on beneficiary's preference. When there is a need for IADL/ADL assistance, could lead to either placement.
  - When beneficiary is in need of Tier 3 Group Home due to physical health/medical risk issues.
  - Specific needs for Group Home Habilitative and Rehabilitative supports and for IADL/Chore services.
  - Based on preferences (e.g., Q4), goals to set in the Recovery Plan, how to assess and review progress with the beneficiary; also, provides basis for motivating when work on ADLs/IADLs is difficult. However, interviewing collaterals (family members, providers) and reviewing the health record for additional data will be needed in most cases in order to fully assess need for IADLs and ADLs.

Services that are provided by third parties must be coordinated with the Residential services provider, including Community-based Rehabilitative services provided outside of the residence. Personal Care services are provided in facilities as part of the Community-based Residential service. To avoid duplication, Personal Care (as a separate service) is not available to beneficiaries receiving Residential services. These services are provided to beneficiaries residing in homes that have no more than nine (9) other residents and with home and community-based characteristics.

Residential services may only be funded through the waiver when the services are not covered by the State Plan, Early and Periodic Screening, Diagnostic, and Treatment (EPDST), or a responsible third-party, such as Medicare or private insurance. Care Managers must assure that coverage of services provided under the State Plan, EPSDT, or a responsible third-party continues until the plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the Recovery Plan. Documentation in accordance with DHSS requirements must be maintained in the beneficiary's file by the Care Manager and updated with each reauthorization, as applicable.

Except as permitted in accordance with requirements contained in DHSS 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. This service may not be included on the same Recovery Plan as the following services: Nursing, Home Health Aide, Personal Care, IADL/Chore, NMT, or Respite.

Residential services should be provided only in facilities meeting home and community-based characteristic requirements and cannot be provided in the following settings or in settings located on the grounds of these facilities:

- Nursing Facility.
- IMD.
- ICF for beneficiaries with IDD.
- Hospital providing long-term care or services.
- Any other location that has qualities of an institutional setting, as determined by DHSS.

Room and Board is excluded from this service. This service must be delivered in Delaware.

The Care Manager must ensure that the provider maintains documentation and that the Care Manager monitors the services on an ongoing basis to ensure that the health and welfare of the beneficiary is met, and the Recovery Plan goals are achieved. The documentation must be available to the Care Manager for monitoring at all times, on an ongoing basis. Documentation in accordance with DHSS requirements must be maintained in the beneficiary's file by the Care Manager and updated with each reauthorization, as applicable.

If the monitoring suggests that a change in tiers is needed, the Care Manager will recommend a re-assessment to re-evaluate the beneficiary to determine the appropriateness of the assigned tier in accordance with DHSS requirements.

The service provider must maintain documentation in accordance with DHSS requirements. The Care Manager will monitor the community character of the residence during regularly scheduled contact with the beneficiary. All the facilities are community-based with a home-like environment providing access to typical home facilities and integrated into the community. Monthly visits will also ensure that the facility maintains a community character at each monthly visit. Community character means that a provider-owned facility ensures that persons are encouraged and afforded the opportunity to exercise their options of when and where to take community outings, have freedom to choose roommates, and are free to exercise personal choices as are other persons who do not qualify for services under the PROMISE program. Beneficiaries participating through Permanent Supported Housing will have freedom to choose their service providers. Beneficiaries will be encouraged to have control over their meal and sleep times, visitor access, privacy, room decorations, and ability to engage freely in the community. Results of this monitoring will be reported to DHSS.

Provider Specifications

Provider Category(s) (check one or both):	☐	Individual (list types):	X	Agency (list types):
			Group Home for Persons with Mental Illness. Supportive Housing Agency.	

Specify whether the service may be provided by (check each that Applies):	☐	Legally Responsible Person.	☐	Relative/Legal Guardian.

Provider Qualifications

Provider Type:	License (specify):	Certificate (specify):	Other Standard (specify):
Group Home for Persons with Mental Illness.	Licensed by the Division of Long-Term Care under DAC Title 16, Chapter 11, Regulation 3305		<u>Facilities for 4–10 Beds</u> • The agency must maintain a staffing ratio consistent with the weighted tiers of the clients in the home. The staff must meet the following qualifications and training: – Psychiatrist — A person with a medical degree or Doctor of Osteopathy degree, who is licensed to practice medicine in Delaware and is board certified in psychiatry or has served a residency in psychiatry. A Licensed Independent Provider (LIP), such as a Nurse Practitioner or Physician's Assistant, may work in this role under formal protocols with the Psychiatrist. – Clinician — A person with a doctoral or master's degree in clinical or counseling psychology, mental health nursing, clinical social work, vocational/psychiatric rehabilitation or education from an accredited college or university; a RN with certification in mental health nursing from the American Nurses Association; or a person with a bachelor's degree with five (5) years' experience in mental health service delivery with at least two (2) years' experience in residential services. – Associate Clinician — A person with a bachelor's degree in clinical or counseling psychology, social work, nursing, vocational/psychiatric rehabilitation, education or other mental health field from an accredited college or university; or a RN. An Associate Clinician shall have had at least two (2) years of direct experience in mental health service.

			– Residence Manager — Responsible for the operation of the Group Home and responsible for the supervision of residents' recovery plans. The qualifications of the Residence Manager must be that of a Clinician (see above). – Peer Specialist — A person with a lived experience of mental illness who has received training in this role and scope of practice. All Peers are certified by the State as Peer Specialists. – Residential Service Assistant — A person who has a high school diploma or equivalent or CNA. (Note: Residential Service Assistants are not permitted to meet staffing qualifications for Tier 4). – **Note: Associate Clinicians and Residential Service Assistants shall have qualifications for the treatment activitiesin which they engage and shall be supervised by the Residence Manager. At least 75% of the Group Home staff shall be Clinicians or Associate Clinicians. 25% should be Peers who work as full members of the multi-disciplinary team. Nothing in these regulations shall be construed to exempt or limit the application of professional licensing requirements, including those pertaining to Professional Counselors, Psychologists, and Clinical Social Workers under 24 Del.C., Chs. 30, 35, and 39, respectively.* ***Note: Nothing in these regulations prohibit a Peer from serving in any of these roles if they also meet the role standards for education and years of experience.* • Accreditation is required for Group Homes with revenues over $500,000 (CARF, TJC). • The service provider shall comply with criminal background check and drug testing laws. • The service provider shall maintain a current personnel policies and procedures manual that sets forth grounds for termination, adequately supports sound resident care and is made readily available to the program's staff in each home. The service provider shall comply with the provisions of such manual. The manual shall contain an explanation of the residents' rights pursuant to 16 Del.C. §1121 and applicable federal law: – Training in risk assessment of dangerousness and interventions aimed at reducing such risk, including training in managing difficult behaviors, in the implementation of de-escalation techniques, and in self-defense techniques to prevent harm from violent behaviors. – Orientation to situational counseling, stress management, and social interaction. – A complete course in medications used in the treatment of mental illness including the medications' effects, side effects, and adverse effects (sometimes life threatening) used alone or in combination with other prescription and non-prescription medication and alcoholic or caffeinated beverages. – A course in the common types of mental illness including signs and symptoms of Schizophrenia, mood and personality disorders, and indications of deterioration of a beneficiary's mental condition. – A course in basic first aid, including basic CPR

			training and basic physical health coaching including healthy diets, adequate exercise, smoking cessation, and routine dental and medical exams and services, as needed. – An explanation of the rights of adults with psychiatric disabilities in Residential care in Delaware. – Expectations for confidentiality and ethical behavior towards residents who will reside in the Group Home. – Policies and procedures that apply to a Group Home on both a daily and emergency basis. – Fire safety and evacuation procedures. – Health care, sanitation, and safe handling of food. – Familiarization with Community-based Behavioral Health services available in the county in which the Group Home is located. – Orientation to situational counseling, de-escalation and mediation techniques, stress management, andsocial interaction. – Training in understanding what recovery actually looks like in terms of outcomes, avoidance of paternalistic approaches, how to support appropriateadult activities and leisure skill development for residents. – Demonstration of a clear understanding of these regulations. – A plan for the continuing education and developmentof staff. – A service provider need not require training in discrete areas in which the staff person has demonstrated competency through satisfactory job performance or previous experience to the satisfaction of the service provider and DHSS. – Staff may be provisionally hired and perform job duties pending completion of training within 30 days.Such provisional staff shall not be on duty without onsite supervision.
Supportive Housing Agency.		Certification by DSAMH.	• The agency must maintain a staffing ratio consistent with the weighted tiers of the beneficiaries in the Supervised Apartments (see staffing ratios in definition above). The staff must meet the qualifications and training below: – Comply with DHSS standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. – Have a waiver provider agreement. – The organization must be able to document three (3) years of experience in providing services to an SPMI population. – Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet the unique needs of the beneficiary (e.g., communication, mobility, and behavioral needs). – Comply with and meet all standards as applied through each phase of the standard, annual DHSS performed monitoring process. – Ensure 24-hour access to personnel (via direct employees or a contract) for response to emergency situations that are related to the Community-based Residential Alternatives service or other waiver

			services. • Employees must: – Be at least 18 years old. – Have a high school diploma or equivalent. – Have a valid driver's license if the operation of a vehicle is necessary to provide the service. – Be certified in the State of Delaware to provide the service, which includes criminal, abuse/neglect registry, and professional background checks, and completion of a State approved standardized basic training program. • If providing Nursing Care, must have qualifications required under State Nurse Practice Act (i.e., RN orLPN). • All Supervised Apartment staff must complete the following State-mandated training: – CPR. – First Aid. – Introduction to Community-based Residential Services for Direct Care Staff. – Air and Blood Borne Pathogens. – Non-Physical Crisis De-Escalation, Crisis Management, and Debriefing. – Proper Techniques to Address Challenging Behavior and Proper Contingency Management. – Principles of Psychiatric Rehabilitation. – Motivational Interviewing for CODs. – Basics of Counseling. – Recovery Oriented Service Delivery & Documentation. – What is Peer Support? – Rights and Responsibilities of Beneficiaries Receiving Mental Health Services. – Cultural Competence and Diversity. – Prevention/Intervention and Recovery/Resiliency Strategies. – Behavioral Health/SUDs and Associated Medical Care and Conditions. – HIPPA and Confidentiality. – Grief, Loss, and Death Notification Procedures. – Applied Suicide Intervention Skills. – Community Integration and Olmstead Decision. – Intro to Human Needs, Values, Guiding Principles, and Effective Teaching Strategies. – Environmental Emergencies: Mitigation, Preparation, and Responding. – Basic Health and Medications. – Advanced Health and Medications. – Nutrition: Food Preparation, Food Storage, Healthy Diet, and Positive Health. – Assessing Mobile Crisis Need.

Verification of Provider Qualifications:

Provider Type:	***Entity Responsible for Verification:***	***Frequency of Verification:***
Group Homes for Persons with Mental Illness.	DHSS or designee.	At least every two (2) years, and more frequently when deemed necessary by DHSS.

Supportive Housing Agency.	DHSS or designee.	At least every two (2) years, and more frequently when deemed necessary by DHSS.

Service Delivery Method				
Service Delivery Method (check each that applies):	☐	Participant-directed.	X	Provider managed.

Billing Method	
Bill Code:	**Billing Rate and Unit:**
T2033: • Residential care, NOS, waiver, per diem, Tier 1. T2033 TF: • Residential care, NOS, waiver, per diem, Tier 2. • TF = Intermediate level of care. T2033 TF UJ: • Residential care, NOS, waiver, per diem, Tier 2. • TF = Intermediate level of care. • UJ = Services provided at night. T2033 TG: • Residential care, NOS, waiver, per diem, Tier 3. • TG = Complex/high-tech level of care. T2033 HK: • Residential care, NOS, waiver, per diem, Tier 4. • HK = Specialized mental health program for high-risk populations.	• Tier 1 (non-ACT) in Supervised Apartment: $74.02. • Tier 2 Day (non-ACT): $53.23. • Tier 2 Night: $40.76. • Tier 3: Up to 5 residents in a Group Home: $328.53. • Tier 3: 6–8 residents in a Group Home: $328.36. • Tier 3: 9–10 residents in a Group Home: $262.69. • Tier 4: Up to 5 residents in a Group Home: $399.28. • Tier 4: 6–8 residents in a Group Home: $328.36. • Tier 4: 9–10 residents in a Group Home: $262.69.
Room and Board:	• Room and Board: Up to 5 residents (non-Medicaid funded): $51.00. • Room and Board: 6–10 residents (non-Medicaid funded): $45.00.
Vacant Bed: • Vacant bed rates, per the appropriate rate listed, may be billed to DSAMH whenever a resident is hospitalized for medical or mental health inpatient stays. When clients are hospitalized: • Vacant bed billings to DSAMH are only applicable to vacant bed rates. DSAMH will not pay Room and Board rates due to inpatient hospitalization. • Overnight visits outside of the group home do not qualify for vacant bed billing. Vacant bed billing arrangements: • Inpatient Hospitalization: The provider may bill DSAMH for vacant beds, daily, per the appropriate rate listed, until the client is discharged from the hospital. The day of return to the group home is FFS billing and no longer billable as a vacant bed. • Group Home Discharge: The provider may bill DSAMH for a vacant bed beginning on	• Tier 3: Up to 5 residents in a Group Home: $328.53. • Tier 3: 6-8 residents in a Group Home: $328.36. • Tier 3: 9-10 residents in a Group Home: 262.69. • Tier 4: Up to 5 residents in a Group Home: $399.28. • Tier 4: 6-8 residents in a Group Home: 328.36. • Tier 4: 9-10 residents in a Group Home: 262.69

the day after notification to DSAMH Eligibility and Enrollment Unit (EEU) of the bed vacancy via the EEU mailbox. Billing may continue for up to 14 days after a referral is submitted by the EEU. Should the referral be rejected, and the rejection has been overturned, the provider must file an appeal within 5 business days, per the EEU Provider Appeals Process Policy. Requests for vacant bed payments beyond the five (5) business days will not be honored. Beds vacant for greater than 14 days due to lack of available clients: • With the prior approval from the Chief of Community Mental Health, the provider may bill DSAMH the vacant bed rate only for beds that remain vacant beyond 14 days due to lack of referrals. Requests must be submitted in writing to the Chief of Community Mental Health and must include detailed information regarding the vacancy, including dates of referral and outreach and all efforts to secure the admission. Prior approval from the Chief of Community Mental Health is required before submission of an invoice requesting payment for vacant bed(s) beyond 14 days. Decisions will be made on a case-by-case basis each month.	

Financial Coaching Plus

Service Specification	
Service Title:	Financial Coaching Plus

Service Definition (Scope):

Financial Coaching Plus uses a financial coaching model to assist beneficiaries 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 assists the beneficiary seeking to improve his/her financial situation 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 beneficiary. Financial Coaching is provided to the beneficiary in a one-on-one setting convenient for the beneficiary over a time-limited series of sessions and follow-up to increase the opportunity for self-directed behavior skills learning.

The Financial Coach:

- Assists the beneficiary in developing financial strategies to reach his/her goals with care to ensure that personal strategies reflect considerations related to benefits, as identified through Benefits Counseling.
- Ensures that beneficiaries understand the availability of various tax credits such as the Earned Income Tax Credit, Childcare Tax Credit, and others.
- Refers beneficiaries, as needed, to Benefit Counselors.
- Provides information to complement information provided through Benefits Counseling, regarding appropriate asset building.
- Uses an integrated dashboard of available community-based asset-building opportunities and financial tools/services to ensure beneficiaries are leveraging all resources to increase economic self-sufficiency.
- Provides information about how to protect personal identify and avoid predatory lending schemes.
- Provides assistance with filing yearly taxes either through the IRS VITA program or its virtual program that involves self-filing.

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

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.

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 other services.

Specify limits (if any) on the amount, duration, or scope of this service for (chose each that applies):

X	***Categorically needy (specify limits):***
	Financial Coaching Plus service limited to five (5) hours per beneficiary per year.
☐	***Medically needy (specify limits):***

Provider Qualifications

Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Financial Coaching Plus Agency.	State Business License or	An agency must demonstrate that Financial Coaches who will provide this service are certified in the	• Comply with DHSS 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

	501(c)(3) status.	financial coaching curriculum developed by DHSS and the University of Delaware Alfred Lerner College of Business and Economics, and the Division of Professional Continuing Studies.	its parent company and subsidiaries, agrees 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 DHSS-required training, including training on the beneficiary's Recovery Plan and the beneficiary's unique and/or disability-specific needs, which may include, but are not limited to, communication, mobility, and behavioral needs. • Individuals employed or contracted by a Financial Coaching Plus Agency must: – Have criminal background investigations in accordance with State requirements. – Have a screening against the child abuse and adult abuse registry checks, 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 finding 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 DHSS. • An agency must demonstrate that Financial Coaches who will provide this service: – Have at least one (1) year of full-time financial coaching experience. – Are trained in Financial Coaching Plus strategies specific to the PROMISE 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.	DHSS or Designee.	Initially and annually (or more frequently, based on service monitoring concerns).

Service Delivery Method				
Service Delivery Method (check each that applies):	☐	Participant-directed.	X	Provider Managed.

Billing Method	
Bill Code:	**Billing Rate and Unit:**
T2013 SE: • Habilitation, educational, waiver, per hour. • SE = State and/or Federally funded programs/services.	• $66.88 per hour.

Instrumental Activities of Daily Living/Chore

Service Specification	
Service Title:	Instrumental Activities of Daily Living/Chore (IADL/Chore)

Service Definition (Scope):

IADL/Chore services are delivered to beneficiaries that reside in a private home and are necessary, as specified in the Recovery Plan, to enable the beneficiary to integrate more fully into the community and to ensure the health, welfare, and safety of the beneficiary.

This service will be provided to meet the beneficiary's needs as determined by an assessment performed in accordance with DHSS requirements, and as outlined in the beneficiary's Recovery Plan.

IADL services consist of the performance of general household tasks (e.g., meal preparation, cleaning, laundry, and other routine household care) provided by a qualified Homemaker when the beneficiary regularly responsible for these activities is absent or unable to manage the home and care for him or herself or others in the home, or when no landlord or provider agency staff is responsible to perform the IADL services.

Chore services consist of services provided to maintain the home in a clean, sanitary, and safe condition. This service includes heavy household chores, such as:

- Washing floors, windows, and walls.
- Tacking down loose rugs and tiles.
- Moving heavy items of furniture in order to provide safe access and egress.
- Removing ice, snow, and/or leaves.
- Yard maintenance.

The providers of this service must review and be familiar with the crisis support plan within the participant's Recovery Plan.

Additional medical necessity criteria for receiving the service, if applicable (specify):

Medical necessity criteria include the following:

- The service is recommended by the Care Manager and the beneficiary in collaboration, and the service is included in the beneficiary's Recovery Plan, AND
- The service is needed to allow the beneficiary the best opportunity to remain in the community, AND
- The tasks required are unable to be completed by the beneficiary or paid or unpaid caregiver, AND
- The beneficiary is not residing in a community-based Group Home, AND
- If the beneficiary is also enrolled in Diamond State Health Plan (DSHP) Plus, the Recovery Plan clearly identifies the types of services needed that are in addition to what is already being provided by DSHP Plus, AND
- The frequency and intensity of the service aligns with the unique needs of the beneficiary. Examples include:
  - A beneficiary has the goal of continuing to live independently in his home. Unfortunately, his brother, who used to help with home repairs and general maintenance, has moved out of State, and the beneficiary has no other family or natural supports to help at this time. The beneficiary is not confident in his ability to take care of his yard due to anxiety when leaving his home, and he has received a notice from the homeowner's association expressing concerns with the condition of his property. IADL/chore has been identified as need to help with yard maintenance once every month.
  - A beneficiary has established a goal of meeting and socializing with her neighbors and friends from church, but states her hoarding behaviors interfere with her comfort in inviting people to her apartment. Monthly IADL/chore assistance with household cleaning and to de-clutter active living areas are needed to facilitate progress in meeting this goal.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

IADL/Chore services may not be billed at the same time as Personal Care or Respite services.

IADL/Chore services are limited to 40 hours per beneficiary per Recovery Plan year when the beneficiary, or family member(s) or friend(s) with whom the beneficiary resides, is temporarily unable to perform and financially provide for the IADL/Chore functions.

The Care Manager must ensure that the provider maintains documentation and that the Care Manager monitors the services on an ongoing basis to ensure that the health and welfare of the beneficiary is met, and the Recovery Plan goals are achieved. The documentation must be available to the Care Manager for monitoring at all times, on an ongoing basis. Documentation in accordance with DHSS requirements must be maintained in the beneficiary's file by the Care Manager and updated with each reauthorization, as applicable.

Provider Specifications

Provider Category(s) (check one or both):	☐	Individual (list types):	X	Agency (list types):
			Home Health Agency. Personal Assistance Services Agency.	

Specify whether the service may be provided by (check each that applies):	☐	Legally Responsible Person.	☐	Relative/Legal Guardian.

Provider Qualifications

Provider Type:	License (specify):	Certificate (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 DHSS standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. • Ensure employees and/or contractors complete DHSS-required training, including training on the beneficiary's Recovery Plan and the beneficiary's unique and/or disability-specific needs, which may include, but are not limited to, communication, mobility, and behavioral needs. • Individuals employed by a Home Health Agency 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 finding in the performance of the service. – In the case of Direct Care personnel, possess certification through successful completion of training program as required by DHSS.
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	N/A.	• Comply with DHSS standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. • Ensure employees and/or contractors complete DHSS-required training, including training on the beneficiary's Recovery Plan and the beneficiary's unique and/or disability-specific needs, which may include, but are not limited to, communication, mobility, and behavioral needs.

	Delaware Code Title 16-4469.		• Individuals employed by a Personal Assistance Services Agency 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 finding in the performance of the service. – In the case of Direct Care personnel, possess certification through successful completion of training program as required by DHSS.

Verification of Provider Qualifications		
Provider Type:	***Entity Responsible for Verification:***	***Frequency of Verification:***
Home Health Agency.	DHSS or Designee.	Initially and annually (or more frequently, based on service monitoring concerns).
Personal Assistance Services Agency.	DHSS or Designee.	Initially and annually (or more frequently, based on service monitoring concerns).

Service Delivery Method				
Service Delivery Method (check each that applies):	☐	Beneficiary-directed.	X	Provider managed.

Billing Method	
Bill Code:	**Billing Rate and Unit:**
S5120: • Chore services, per 15 minutes.	• Home Health Agency: $6.58 per 15 minutes. • Personal Assistance Agency: $5.85 per 15 minutes.

Individual Employment Support Services

Service Specification	
Service Title:	Individual Employment Support Services (IESS)

Service Definition (Scope):

IESSs are services for beneficiaries needing ongoing, individualized support to learn a new job or to maintain a job in a competitive or customized integrated work setting that meets job and career goals (including self-employment). Beneficiaries in a competitive employment arrangement receiving IESSs are compensated at or above the minimum wage and receive similar wages and levels of benefits paid by the employer for the same or similar work performed by beneficiaries without disabilities. IESSs are necessary, as specified in the Recovery Plan, to support the beneficiary to live and work successfully in home and community-based settings, enable the beneficiary to integrate more fully into the community, and ensure the health, welfare, and safety of the beneficiary.

Supported Employment may also include support to establish or maintain self-employment, including home-based self-employment. Supported Employment services are individualized and may include any combination of the following services: ongoing vocational/job-related discovery or assessment not otherwise covered in the annual career planning, ongoing person-centered employment planning not otherwise covered in the annual career planning, job placement, job development negotiation with prospective employers, job analysis, job carving, training and systematic instruction, individual supports, benefits support training, planning, transportation, asset development and career advancement services, implementation of assistive technology, and other workforce support services including services not specifically related to job skill training that enable the waiver beneficiary to be successful in integrating into the job setting. Supported Employment includes person-centered, comprehensive employment planning and support services that provide assistance for waiver program beneficiaries to obtain, maintain, or advance in competitive employment or self-employment. This employment planning includes engaging a beneficiary 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 activity is identification of the beneficiary's career objective and development of a career plan used to guide beneficiary to gain competitive employment.

Competitive or customized integrated employment, including self-employment, shall be considered the first option when serving beneficiaries with disabilities who are of working age. IESSs adopt a "rapid job search" approach to achieving competitive employment and services planned do not assume that a beneficiary must achieve greater readiness for competitive employment before competitive employment is sought.

Supported Employment may provide work experiences where the beneficiary can develop strengths and skills that contribute to employability in paid employment in integrated community settings. IESS includes supervision, monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills and training and education in self-determination. Skills development, as a part of placement and training, may occur as a one-on-one training experience in accordance with DHSS requirements. IESS may be utilized for a beneficiary to gain work-related experience considered crucial for job placement (e.g., unpaid internship), if such experience is vital to the person achieve his or her vocational goal. IESS provides and supports the acquisition of skills necessary to enable the beneficiary to obtain competitive, integrated work where the compensation for the beneficiary is 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 beneficiaries without disabilities, which is considered to be the optimal outcome of IESS.

In addition to the elements note above, IESS provides two (2) components in accordance with an assessment: Intensive IESS (IIESS) and Extended Follow Along (EFA).

IIESS

IIESS is an essential component of IESS and may include:

- On-the-job training and skills development.
- Assisting the beneficiary with development of natural supports in the workplace.
- Helping the beneficiary to attend school and providing academic supports, when that is their preference, AND

- Coordinating with employers or employees, coworkers, and customers, as necessary (*Note: Coordinating with employers and other employees is done only if the beneficiary prefers to have her or his mental illness disclosed and gives permission. Supporting the beneficiary's preference in this area is fundamental to recovery*).
- Providing work incentives planning prior to or during the process of job placement. Work incentives planning involves helping the beneficiary review her or his options for working (number of hours per week, etc.), given the hourly pay the beneficiary's being offered, or is likely to be offered, the beneficiary's current income needs, and the rules concerning how Social Security Administration benefits, medical benefits, medical subsidies, and other subsidies (housing, food stamps, etc.) change based on income from paid employment. (This includes providing information on Ticket to Work, etc.). Work incentive planning allows beneficiaries to make informed decisions about how many hours per week to work, as well as their preferred timing in moving from part-time to full-time work. Beneficiaries also are given information and assistance about reporting earnings to various sources of entitlements/benefits.
- Assisting beneficiaries in making informed decisions about whether to disclose their mental illness condition to employers and co-workers.

IIESS includes assisting the beneficiary in meeting employment expectations, performing business functions, addressing issues as they arise, and also includes travel training and diversity training to the specific business where the beneficiary is employed. IIESS provides support to assist beneficiaries in stabilizing in an integrated situation (including self-employment) and may include activities on behalf of the beneficiary when the beneficiary is not present to assist in maintaining job placement. Once the beneficiary is stable in the position, EFA will ensue.

EFA

EFA is ongoing support available for an indefinite period as needed by the beneficiary to maintain their paid employment position once they have been stabilized in their position (generally receiving on-site support once per month or less). EFA support may include reminders of effective workplace practices and reinforcement of skills gained during the period of IIESS.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

IESS may not be rendered to a beneficiary eligible for services under a program funded by either the Rehabilitation Act of 1973, the IDEA, or any other small business development resource available to the beneficiary (e.g., during the job placement phase or the first 90 days of placement if the Vocational Rehabilitation State agency is reimbursing the Supported Employment provider)

This service must occur in integrated settings and may not occur in non-integrated settings.

IESS services do not include volunteer work and may not be for job placements paying below minimum wage.

Services must be delivered in a manner that supports the beneficiary's communication needs including, but not limited to, age-appropriate communication, translation/Interpretation services for beneficiaries that are of limited-English proficiency, or who have other communication needs requiring translation, and assistance with the provider's understanding and use of communication devices used by the beneficiary.

This service may be delivered in Delaware and in states contiguous to Delaware.

The IESS service provider must maintain documentation in accordance with DHSS requirements. The documentation must be available to the Case Manager for monitoring at all times on an ongoing basis. The Case Manager will monitor on a quarterly basis to see if the objectives and outcomes are being met.

Except as permitted in accordance with requirements contained in DHSS 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.

Federal Financial Participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in IESS.
- Payments that are passed through to beneficiaries using IESS.

IESS 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.

IESS does not include payment for supervision, training, support, and adaptations typically available to other non-disabled workers filling similar positions in the business.

IESS provided by an ACT/ICM team is billed only when Supported Employment goals and activities are specifically outlined on the beneficiary's Recovery Plan. The team may bill up to one (1) extra bachelor's level unit for the Team Vocational Specialist per month when vocational activities were conducted with the team consistent with the TMACT fidelity model. Documentation must be maintained regarding the vocational activities performed and the goals/activities completed for each beneficiary in the beneficiary's medical record maintained by the provider.

The Care Manager must ensure that the provider maintains documentation and that the Care Manager monitors the services on an ongoing basis to ensure that the health and welfare of the beneficiary is met, and the Recovery Plan goals are achieved. The documentation must be available to the Care Manager for monitoring at all times, on an ongoing basis. Documentation in accordance with DHSS requirements must be maintained in the beneficiary's file by the Care Manager and updated with each reauthorization, as applicable.

Provider Specifications

Provider Category(s) (check one or both):	X	Individual (list types):	X	Agency (list types):
	IESS Provider.		IESS Provider Agency.	
Specify whether the service may be provided by (check each that applies):	☐	Legally Responsible Person.	☐	Relative/Legal Guardian.

Provider Qualifications

Provider Type:	**License (specify):**	**Certificate (specify):**	**Other Standard (specify):**
IESS Provider Agency.		Current State motor vehicle registration is required for all vehicles owned, leased, and/or hired and used as a component of the IESS service. Certified by DSAMH as a team in fidelity with the EBP for Employment Supports.	• Comply with applicable State regulations and have a PROMISE provider agreement. • Comply with DHSS standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. • Have or ensure automobile insurance for any automobiles owned, leased, and/or hired when used as a component of the service. • Have Worker's Compensation insurance in accordance with State statute and in accordance with DHSS policies. • Have Commercial General Liability insurance. • Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet the unique needs of the beneficiary (e.g., communication, mobility, and behavioral needs). • Comply with Individual Placement and Support (IPS) fidelity requirements in Appendix 3. • Individuals working for or contracted with an IESS Provider Agency must: – Be at least 18 years of age, AND – Have a bachelor's degree, AND – Have a minimum of one (1) year of experience living or working with a beneficiary with a disability or support needs commensurate with the beneficiaries served in the waiver or related educational experience.

			– Comply with DHSS standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. – Complete DHSS-required training for the EBP, including training on the beneficiary's Recovery Plan and the beneficiary's unique needs, which may include, but is not limited to, communication, mobility, and behavioral needs. – Have criminal clearances. – Have a valid driver's license if the operation of a vehicle is necessary to provide the service. – Be supervised by a Team Lead who has received specific EBP training.
ACT Team (including specialized SUD ACT team and ACT reintegration team).		Certification by DSAMH as an ACT team in fidelity with TMACT.	• In compliance with TMACT fidelity (scoring at least a 3.0) or having provisional certification, ACT teams may provide any component of the services listed and must employ and utilize the qualified State Plan providers (i.e., Physicians, Licensed Practitioners) and HCBS providers necessary to maintain fidelity, including CPST specialists. • Employment specialists on an ACT team must: – Be at least 18 years old. – Meet the regulatory requirements for Associate Clinicians, such as a person with a bachelor's degree in a human service field. – Be certified in the State of Delaware to provide the service, which includes criminal, abuse/neglect registry, and professional background checks, and completion of a State approved standardized basic training program. • Anyone providing SUD services must be certified by DHSS, in addition to any required scope of practice license required for the facility or agency to practice in the State.
ICM Team.		Certification by DSAMH in fidelity with State ICM standards.	• In compliance with State mandates under the settlement, ICM teams may provide any component of the services listed and must employ and utilize the qualified State Plan providers (i.e., Physicians, Licensed Practitioners) and HCBS providers necessary to maintain fidelity, including employment specialists. ACT teams not meeting provisional certification or having fidelity below 3.0 are ICM teams. • Employment specialists on an ICM team must: – Be at least 18 years old, and meet the regulatory requirements for Associate Clinicians, such as a person with a bachelor's degree in a human service field. – Be certified in the State of Delaware to provide the service, which includes criminal, abuse/neglect registry, and professional background checks, and completion of a State approved standardized basic training program. • Anyone providing SUD services must be certified by DHSS, in addition to any required scope of practice

			license required for the facility or agency to practice in the State.

Verification of Provider Qualifications:		
Provider Type:	***Entity Responsible for Verification:***	***Frequency of Verification:***
IESS Provider Agency.	DHSS or designee.	At least every two (2) years, and more frequently when deemed necessary by DHSS.
IESS Provider.	DHSS or designee.	At least every two (2) years, and more frequently when deemed necessary by DHSS.

Service Delivery Method				
Service Delivery Method (check each that applies):	X	Beneficiary-directed.	X	Provider managed.

Billing Method	
Bill Code:	**Bill Rate and Unit:**
H2023 SE: • Supported Employment, per 15 minutes. • SE = State and/or federally funded programs/services.	• Year 1: $18.51. • Year 2: $18.30.
Individual Employment Support services provided by a bachelor's level therapist on an ACT or ICM team should refer to the CPST section of this manual for appropriate ACT/ICM billing codes and rates for this service.	

Non-Medical Transportation

Service Specification	
Service Title:	Non-medical Transportation (NMT)
Service Definition (Scope):	
NMT services are offered in addition to any Medical Transportation furnished under the 42 CFR 440.17(a) in the State Plan. NMT services are necessary, as specified by the Recovery Plan, to enable beneficiaries to gain access to waiver services that enable them to integrate more fully into the community and ensure the health, welfare, and safety of the beneficiary. In order to be approved, NMT needs to be directly related to a goal on the beneficiary's Recovery Plan (e.g., to a Supported Employment job), and not for the general transportation needs of the beneficiary (e.g., regular trips to the grocery store). This service will be provided to meet the beneficiary's needs as determined by an assessment performed in accordance with DHSS requirements, and as specifically outlined in the beneficiary's Recovery Plan. Transportation services under the PROMISE program are offered in accordance with the beneficiary's Recovery 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. Transportation services will be delivered through a Transportation Broker who will arrange and/or provide services pursuant to the Recovery Plan. Such transportation may also include public transportation. The utilization of public transportation promotes self-determination and is made available to beneficiaries as a cost-effective means of accessing services and activities. This service provides payment for the beneficiary's use of public transportation to access employment. The Care Manager will monitor this service quarterly and will provide ongoing assistance to the beneficiary 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 medical necessity criteria for receiving the service, if applicable (specify):	
Medical necessity criteria include the following: • The service is recommended by the Care Manager and the beneficiary in collaboration, and the service is included in the beneficiary's Recovery Plan, OR • The service is directly related to a goal on the beneficiary's Recovery Plan related to community integration and/or employment, AND the following criteria must be met: — The service is needed to allow the beneficiary the best opportunity to remain in the community, AND — The beneficiary has no other means of transportation available (e.g., family, neighbors, friends, carpools, co-workers, natural supports, community agencies), AND — The service is not intended to meet the general transportation needs of the beneficiary in an ongoing fashion, AND — The service is not provided during the performance of the beneficiary's paid employment, AND — The frequency and intensity of the service aligns with the unique needs of the beneficiary. Examples include: • A beneficiary identifies the need for public transportation support to help her get to and from her new job she obtained through Supported Employment efforts. • A beneficiary has established a goal to increase his social support network and needs NMT to a peer-operated program two (2) days per week for the next three (3) months.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Transportation services provided through the waiver will not be used for obtaining State Plan services. The beneficiary's Recovery Plan must document the need for those NMT services that are not covered under the Medical Assistance Transportation Program.	

NMT services may only be included in the Recovery Plan after an individualized determination that the method is the most cost-effective manner to provide needed Transportation services to the beneficiary, and that all other non-Medicaid sources of transportation which can provide this service without charge (such as family, neighbors, friends, community agencies), have been exhausted.

Services that cannot be claimed as NMT services include:

- Services not authorized by the Recovery Plan.
- Trips that have no specified purpose or destination.
- Trips for family, provider, or staff convenience.
- Transportation provided by the beneficiary.
- Transportation provided by the beneficiary's spouse.
- Transportation provided by the biological, step, or adoptive parents of the beneficiary or legal guardian, when the beneficiary is a minor.
- Trips when the beneficiary is not in the vehicle.
- Transportation claimed for more than one (1) beneficiary per vehicle at the same time or for the same miles, except public transportation.
- Transportation outside the State of Delaware, unless:
  - The transportation is provided to access the nearest available Medical or Therapeutic service.
  - Advance written approval is given by the Care Manager.
- Services that are mandated to be provided by the public schools as specified in the beneficiary's Individualized Education Program (IEP), pursuant to IDEA.
- Services that are mandated to be provided by Vocational Rehabilitation as specified in the beneficiary's IEP, pursuant to the Rehabilitation Act of 1973.

NMT does not pay for vehicle purchases, rentals, modifications, or repairs.

NMT cannot be provided at the same time a service when the provider is responsible for providing transportation integral to the service or for providing transportation to and from the service.

Except as permitted in accordance with requirements contained in DHSS 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. This service may not be included on the same Recovery Plan as Community-based Residential Alternatives/Assisted Living/ACT/ICM, as the providers of these services are responsible for transportation and in these situations the cost of transportation is built into the rate.

The Care Manager must ensure that the provider maintains documentation and that the Care Manager monitors the services on an ongoing basis to ensure that the health and welfare of the beneficiary is met, and the Recovery Plan goals are achieved. The documentation must be available to the Care Manager for monitoring at all times, on an ongoing basis. Documentation in accordance with DHSS requirements must be maintained in the beneficiary's file by the Care Manager and updated with each reauthorization, as applicable.

Provider Specifications				
Provider Category(s) (check one or both):	X	Individual (list types):	X	Agency (list types): Transportation Broker Agency.
Specify whether the service may be provided by (check each that applies):	☐	Legally Responsible Person.	X	Relative/Legal Guardian.

Provider Qualifications			
Provider Type:	**License (specify):**	**Certificate (specify):**	**Other Standard (specify):**
Transportation Broker Agency.	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:		
Provider Type:	***Entity Responsible for Verification:***	***Frequency of Verification:***
Transportation Broker Agency.	DHSS or Designee.	Initially and annually (or more frequently, based on service monitoring concerns).

Service Delivery Method				
Service Delivery Method (check each that applies):	☐	Participant-directed.	X	Provider managed.

Billing Method	
Bill Code:	**Billing Rate and Unit:**
A0090: • Non-emergency Transportation, per mile: vehicle provided by beneficiary (family member, self, neighbor) with vested interest. A0100: • Non-emergency Transportation: taxi. A0110: • Non-emergency Transportation and bus, intra, or interstate carrier. A0120: • Non-emergency Transportation: mini-bus, mountain area transports, or other transportation systems. A0130: • Non-emergency Transportation: wheelchair van. A0170: • Transportation ancillary: parking fees, tolls, other. T2003 SE: • Non-emergency Transportation; encounter/trip. • SE — State and/or federally-funded programs/services. *Note: planned for future rate setting, but not for initial implementation. Eventually for the PROMISE program, use healthcare common procedure coding system (HCPCS) code T2003 once per calendar month using from and through dates.) T2003 Non-emergency Transportation; encounter/trip.*	See fee-for-service fee schedule from transportation broker.

Nursing

Service Specification	
Service Title:	Nursing

Service Definition (Scope):

Nursing services are prescribed by a Physician in addition to any services under the State Plan, as determined by an assessment in accordance with DHSS requirements. Nursing services are necessary, as specified in the Recovery Plan, to enable the beneficiary to integrate more fully into the community and ensure the health, welfare, and safety of the beneficiary. This service is intended to be utilized in the beneficiary's home.

Services are provided by a RN or LPN under the supervision of a RN licensed to practice in the State. The Physician's order to reauthorize must be obtained every 90 days for continuation of service. If the beneficiary is receiving Nursing services, the Care Manager must ensure that a Physician's order is in place prior to initiation of the services. If changes in the beneficiary's status take place after the Physician's order, but prior to the reauthorization of the service, and result in a change in the level of services authorized in the Recovery Plan, the provider is responsible for reporting to the ordering Physician and Care Manager.

Nursing services must be performed by a RN or LPN, as defined by the State Nurse Practice Act. Skilled Nursing is typically provided on a one-on-one basis and can be continuous, intermittent, or short-term, based on the beneficiary's assessed need:

- Short-term or Intermittent Nursing — Nursing that is provided on a short-term or intermittent basis, not expected to exceed 75 units of service in a Recovery Plan year and are over and above services available to the beneficiary through the State Plan.
- Long-term or Continuous Nursing — Long-term or continuous Nursing is needed to meet ongoing assessed needs that are likely to require services in excess of 75 units per Recovery Plan year, are provided on a regular basis, and are over and above services available to the beneficiary through the State Plan.

Services must be delivered in a manner that supports the beneficiary's communication needs including, but not limited to, age-appropriate communication, translation/Interpretation services for beneficiaries that are of limited-English proficiency, or who have other communication needs requiring translation, and assistance with the provider's understanding and use of communication devices used by the beneficiary.

The Nursing service provider must maintain documentation in accordance with DHSS requirements. The Care Manager will monitor at least on a quarterly basis to see if the objectives and outcomes are being met.

Additional medical necessity criteria for receiving the service, if applicable (specify):

Medical necessity criteria include the following:

- The service is recommended by a Physician or other practitioner of the healing arts acting within their scope of practice and the service is included in the beneficiary's Recovery Plan, AND
- In-home Psychiatric Nursing is needed to allow the beneficiary the best opportunity to remain in the community, AND
- For beneficiaries on an ACT team, enrolled in DSHP or enrolled in DSHP Plus, the Recovery Plan clearly identifies the types of Nursing services and interventions needed that are in addition to what is already being provided by Medicaid State Plan services, DSHP Plus, and/or an ACT/ICM team, AND
- The beneficiary is not receiving the service through a Community-based Residential Alternative Setting Tier 3 or 4 Group Home or institutional setting, AND
- The frequency and intensity of the service aligns with the unique Nursing needs of the beneficiary. Examples include:
  - — A beneficiary has a goal of learning how to better manage her numerous medications, so she doesnot accidentally mix them up or miss a dose. A weekly visit by a Nurse is recommended by her Psychiatrist to assist her with medication set up and monitoring for the next three (3) months.
  - – A beneficiary is not confident in his ability to appropriately clean, dress, and take care of the severely dry, cracked skin he experiences. This contributes to anxiety, compulsive washing, and

missing days of work. A weekly visit by a Nurse is recommended to assess his skin condition and to educate him on skin care for the next six (6) months.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Nursing services may only be funded through the waiver when the services are not covered by the State Plan, EPDST, or a responsible third-party, such as Medicare or private insurance. Care Managers must assure that coverage of services provided under the State Plan, EPSDT, or a responsible third-party continues until the plan limitations have been reached or a determination of non-coverage has been established prior to this services inclusion in the Recovery Plan. For example, if a beneficiary requests Nursing on his or her Recovery Plan, the Care Manager must ensure that State Plan Home Health Nursing benefit through the MCO is first exhausted. Documentation in accordance with DHSS requirements must be maintained in the beneficiary's file by the Care Manager and updated with each reauthorization, as applicable. The Nursing Care must be ordered by the beneficiary's primary care Physician or another non-behavioral health Physician.

Nursing services must be prior authorized by DHSS and are only available to the extent that the specific tasks required are unable to be completed by a beneficiary or paid or unpaid caregiver and require the skills of a Licensed Nurse. The most appropriate level of Nursing must be used for a task.

Nursing provided at a ratio other than on a one-on-one basis must be approved by DHSS.

Except as permitted in accordance with requirements contained in DHSS 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. This service may not be included on the same Recovery Plan as Community-based Residential Alternatives Tiers 3 and 4 provided in a Group Home or if the beneficiary receives ACT/ICM.

The Care Manager must ensure that the provider maintains documentation and that the Care Manager monitors the services on an ongoing basis to ensure that the health and welfare of the beneficiary is met, and the Recovery Plan goals are achieved. The documentation must be available to the Care Manager for monitoring at all times, on an ongoing basis. Documentation in accordance with DHSS requirements must be maintained in the beneficiary's file by the Care Manager and updated with each reauthorization, as applicable.

Provider Specifications

Provider Category(s) (check one or both):	☐	Individual (list types):	X	Agency (list types):
				Home Health Agency. Private Duty Nursing Agency.

Specify whether the service may be provided by (check each that applies):	☐	Legally Responsible Person.	☐	Relative/Legal Guardian.

Provider Qualifications

Provider Type:	License (specify):	Certificate (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 DHSS standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. • Ensure employees and/or contractors complete DHSS-required training, including training on the beneficiary's Recovery Plan and the beneficiary's unique and/or disability-specific needs, which may include, but are not limited to, communication, mobility, and behavioral needs. • Individuals employed by a Home Health Agency 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, 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 finding in the performance of the service. – In the case of Direct Care personnel, possess certification through successful completion of training program as required by DHSS and be a RN or LPN.
Private Duty Nursing Agency.			Enrolled under the Medicaid State Plan as a Private Duty Nursing Agency provider and practitioners meet all State Plan requirements as a RN or LPN.

Verification of Provider Qualifications:

Provider Type:	***Entity Responsible for Verification:***	***Frequency of Verification:***
Home Health Agency.	DHSS or Designee.	Initially and annually (or more frequently, based on service monitoring concerns).
Private Duty Nursing Agency.	DHSS or Designee.	Initially and annually (or more frequently, based on service monitoring concerns).

Service Delivery Method

Service Delivery Method (check each that applies):	☐	Participant-directed.	X	Provider managed.

Billing Method

Bill Code:	**Billing Rate and Unit:**
S9123: • Nursing Care, in the home, by a RN, per hour (use for general Nursing Care only, not to be used when CPT codes 99500–99602 can be used). S9124: • Nursing Care, in the home, by a LPN, per hour.	• RN: $51.50 (Home Health and Private Duty Nursing) per hour. • LPN: $46.14 (Home Health and Private Duty Nursing) per hour.

Peer Supports

Service Specification	
Service Title:	Peer Supports
Service Definition (Scope):	

Peer Support services are person-centered services with a rehabilitation and recovery focus designed to promote skills for coping with and managing psychiatric symptoms, while facilitating the utilization of natural resources and the enhancement of recovery-oriented attitudes such as hope and self-efficacy, and community living skills. Activities included must be intended to achieve the identified goals or objectives as set forth in the beneficiary's Recovery Plan, which delineates specific goals that are flexibly tailored to the beneficiary and attempt to utilize community and natural supports. The structured, scheduled activities provided by this service emphasize the opportunity for beneficiaries to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery.

A Peer Specialist uses lived experience with a mental illness, SUD, or another COD, such as physical health, IDD, etc., or assists in supporting beneficiaries in their recovery path.

Peer Supports may include the following components:

- Helping the beneficiary aspire to and attain roles which emphasize their strengths by:
  - Sharing parts of their own personal recovery story and first-hand experiences.
  - Providing mutual support, hope, reassurance, and advocacy.
- Providing support to the beneficiary regarding understanding their symptoms of mental illness and effects of trauma and trauma history and developing positive coping skills.
- Engaging the beneficiary through outreach and support.
- Assisting the beneficiary to advocate for self and others.
- Promoting recovery through modeling by:
  - Sharing one's own personal recovery story.
  - Displaying of self-confidence and self-determination.
  - Using natural supports, including connections to friends and family, peer mutual help groups, and other supports in the community.
  - Displaying personal achievements of personal recovery goals.
- Helping the beneficiary to develop a network for information and support from others who have been through similar experiences.
- Assisting the beneficiary with gaining and regaining the ability to make independent choices and to take a proactive role in treatment, including discussing questions or concerns about medications, diagnoses, or treatment approaches with their treating Clinician.
- Assisting the beneficiary with identifying and effectively responding to or avoiding identified precursors or triggers that result in functional impairments.
- Assisting the beneficiary to complete peer-related elements of a comprehensive assessment.
- Preparing the beneficiary to attend their recovery plan meetings and is present to assist them express their goals and needs.
- Assisting the beneficiary to accomplish their life goals of living in a chosen community, including working in a job and engaging in activities, including leisure activities, to support community integration, having a natural support system in place, and having a number of hobbies or activities that are creative and integrated community leisure activities.
- Working with the beneficiary and staff in developing and implementing person-directed beneficiary recovery plans, using both their own expertise, based on their lived experience, as well as evidence-based tools, such as the Wellness Recovery Action Plan.
- Assisting in helping the beneficiary to work on their beneficiary wellness plan for physical and emotional wellness. These services might include physical exercise, dietary assistance, recognition of medical/healthcare needs, introduction to alternative healing techniques such as meditation or massage, etc. Peer Specialists are primarily expected to engage beneficiaries and provide personalized individualized support toward recovery. However, Peer Specialists may assist with IADLs

when they are assessed to be important aspects of the recovery process for a person to whom the Peer Specialist is providing services, consistent with the broader Peer Support role.

- Facilitating peer recovery support groups.
- Accompanying beneficiaries to appointments which connect them to community resources and services. Under this service, the Peer Specialist should not provide Transportation. If the Peer Specialist provides NMT, the Peer Specialist should be enrolled as a Transportation provider and separately charge for the NMT service instead of Peer Support. Peer Specialists should not be routinely used to provide client transportation.
- Acting as an advocate for beneficiaries to secure needed services, financial entitlements, and effectively raise complaints and suggestions about unmet needs, and helping beneficiaries develop self-advocacy skills.
- Locating peer-run programs, and support groups for interested beneficiaries.
- Participating in the ongoing engagement of beneficiaries.

A Peer Specialist should ensure that the following occur:

- Maintain compliance with all applicable practice standards and guidelines.
- Maintain beneficiary confidentiality and adherence to Health Insurance Portability & Accountability Act requirement at all times.
- Complete all required documentation in a timely manner consistent with agency guidelines.
- Maintain agency-required productivity standards built into the State's rates.

Peer Specialists may function within a team or work with the beneficiary on an individual basis. Peer Specialists may serve on ACT and ICM teams. If the Peer Specialist functions within a team, then the Peer Specialist:

- Provides training and education to the beneficiary and other members of the beneficiary's team on:
  - Recovery-oriented care and processes.
  - Local and national Peer Support resources and advocacy organizations.
  - Psychiatric advance directives: advocacy, information, and referral.
  - Recovery planning, illness self-management, and wellness tools.
  - Trauma informed care.
  - Use of expressive therapies.
- Is not used primarily to complete tasks that Clinicians or other specialists on the team do not want to complete, such as transport beneficiaries, complete paperwork, and so on.

Peer Support is a face-to-face intervention with the beneficiary present. Services may be provided individually or in a group setting. The majority of Peer Support contacts must occur in community locations where the person lives, works, attends school, and/or socializes.

Additional medical necessity criteria for receiving the service, if applicable (specify):

For beneficiaries not receiving ACT/ICM, medical necessity criteria includes the following:

- The service is recommended by the Care Manager and the beneficiary in collaboration, AND
- The service is included in the beneficiary's Recovery Plan, AND
- The service is needed to allow the beneficiary the best opportunity to remain in the community, AND
- The frequency and intensity of the service aligns with the unique needs of the beneficiary. Examples include:
  - A beneficiary being discharged from an Inpatient setting after three (3) admissions in six (6) months has identified a goal of being able to better self-manage the ongoing symptoms of his mental illness. He identifies the need for four (4) hours per day of Peer Support for the next three (3) months to help him cope with and self-manage ongoing depressive symptoms, and to becomebetter engaged in outpatient services.
  - A beneficiary has the goal of preparing meals for herself and her family on a weekly basis but is not comfortable going to the grocery store alone due to challenges with agoraphobia and panic attacks. Peer Support is being requested once a week to provide support, hope, and outreach and to accompany her on short trips to the grocery store.

- A beneficiary has identified a goal of engaging in more healthy leisure activities and believes it would be beneficial to have more access to peers to support this effort. Peer Support is needed three (3) times per week to offer access to group activities with peers.

For beneficiaries receiving ACT, medical necessity criteria includes the following:

- ACT admission criteria (see Appendix 1 Section 1.1 for a complete listing of admission criteria):
  - Must be certified by the Psychiatric prescriber.
  - SPMI that seriously impairs a beneficiary's ability to live in the community.
  - Priority is for beneficiaries with Schizophrenia, other psychotic disorders, Bipolar Disorder.
  - Must have primary mental health diagnosis or COD.
  - Beneficiaries with only SUD/IDD, brain injury, or personality disorder **are not intended recipients.**
  - May have repeated hospitalizations with SUD issues.
  - Must meet the ACT admission criteria at Appendix 1 including 3.1.1, 3.1.2, or 3.1.3:
    - Difficulty performing daily tasks for basic adult functioning in the community (e.g., personal business; obtaining medical, legal, and housing services; recognizing and avoiding common dangers to self and possessions; meeting nutritional needs; maintaining personal hygiene).
    - Significant difficulty maintaining consistent employment at a self-sustaining level, or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks).
    - Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).
    - High use of Acute Hospitals (two (2) or more admissions per year) or Psychiatric Emergency services.
    - Intractable (persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).
    - Co-occurring substance use and SPMI or SMI of significant duration (e.g., greater than six (6) months).
    - High risk or recent history of criminal justice involvement (e.g., arrest and incarceration).
    - Significant difficulty meeting basic survival needs, residing in substandard housing, homeless, or at imminent risk of becoming homeless.
    - Residing in an inpatient or Supervised Community Residence, but clinically assessed to be able to live in a more independent living situation if Intensive services are provided, or requiring a residential or institutional placement if more Intensive services are not available.
    - Difficulty effectively utilizing traditional office-based Outpatient services or other less-intensive community-based programs (e.g., beneficiary fails to progress, drops out of services).
- Admission documentation must include:
  - Evidence that one of the criteria is met.
  - The reasons for admission are stated by BOTH the beneficiary and ACT team.
  - Signature of the Psychiatric prescriber.
  - Engagement/enrollment into ACT must begin within five (5) days of referral to ACT.
  - A review of medical necessity can be initiated at any time, but treatment team notes must regularly reflect all life domains and ongoing medical necessity of services.
- ACT discharge criteria:
  - Minimum of four (4) hours of services per month.
  - If fewer than four (4) hours is provided during the course of six (6) months due to recovery progress, the level of care must be evaluated.
  - Changes in Recovery Plan goals.
  - Plans for continuing care in the next month.

For beneficiaries receiving ICM, medical necessity criteria includes the following:

- ICM admission criteria (see Appendix 2 Section 3.1 for a complete listing of admission criteria):
  - Must be certified by the Psychiatric prescriber.
  - SPMI that seriously impairs a beneficiary's ability to live in the community.

- Priority is for beneficiaries with Schizophrenia, other psychotic disorders, Bipolar Disorder.
- Must have primary mental health diagnosis or COD.
- Beneficiaries with only SUD/IDD, brain injury, or personality disorder **are not intended recipients.**
- May have repeated hospitalizations with SUD issues.
- Diagnoses that would otherwise be excluded from ICM services may be considered for an ICM team if an assessment by the team supports ICM services as the best course of action.
- Must have at least one of the following (#'s 1-4):
  - Difficulty performing daily tasks for basic adult functioning in the community (e.g., personal business; obtaining medical, legal, and housing services; recognizing and avoiding common dangers to self and possessions; meeting nutritional needs; maintaining personal hygiene).
  - Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks).
  - Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).
  - Continuous high service needs as demonstrated by at least one of the following:
    - Co-occurring substance use and SPMI or SMI of significant duration (e.g., greater than six (6) months).
    - High risk or recent history of criminal justice involvement (e.g., arrest and incarceration).
    - Difficulty effectively utilizing traditional office-based Outpatient services or other less-intensive community-based programs (e.g., beneficiary fails to progress, drops out of services).

- ICM discharge criteria:
  - Requests for discharge from services shall occur when a beneficiary:
    - Has successfully reached individually established goals (i.e., demonstrates an ability to function in all major role areas such as work, social, self-care) for discharge, and when the beneficiary and program staff mutually agrees to the transition to less intensive services).
    - Moves outside the geographic area of ICM responsibility. In such cases, the ICM team shall arrange for transfer of Mental Health service responsibility to an ACT or ICM program or another provider wherever the beneficiary is moving. The ICM team shall maintain contact with the beneficiary until this service transfer is complete.
    - Declines or refuses services and requests discharge despite the team's documented best efforts to utilize appropriate engagement techniques to develop a mutually acceptable participant-directed Recovery Plan with the beneficiary:
      - Prior to discharge from ICM services, the EEU shall approve and/or request further information to review the circumstances, clinical situation, risk factors, and attempted strategies to engage the beneficiary.
  - In addition to the discharge criteria listed above, based on mutual agreement within the ICM team, a beneficiary discharge may also be facilitated due to any one of the following circumstances:
    - Death.
    - Inability to locate the beneficiary despite documented active outreach efforts by the team for a period of 90 continuous days.
    - Incarceration of 90 days or more.
    - Hospitalization or Nursing Facility care where it has been determined, based on mutual agreement by the Hospital or Nursing Facility treatment team and the ICM team, with approval by the EEU, that the beneficiary will not be appropriate for discharge from the Hospital or Nursing Facility for a prolonged period of time.

Specify Applicable (if any) Limits on the Amount, Frequency, or Duration of this Service:

Peer Support is available daily for no more than four (4) hours per day for an individual beneficiary. The maximum group size for group settings for this service is no more than 1:8. Progress notes document beneficiary progress relative to goals identified in the Recovery plan. On a monthly basis, the progress notes indicate where treatment goals have not yet been achieved. The yearly limit is 750 hours of group

Peer Support (or a combination of group PSR and group Peer Support) per calendar year. This limit can be exceeded when medically necessary through prior authorization. Medicaid reimburses for Peer Support services delivered directly to Medicaid beneficiaries. Attendance at team meetings is an indirect cost built into the team Peer Specialist rates and may not be billed for directly. Beneficiaries receiving SUD or COD-SUD Recovery Coach services should receive those services under the State Plan prior to accessing PROMISE services, unless it is determined that Peer Support services delivered by a mental health Peer Specialist is a more appropriate service. Beneficiaries enrolled in ACT/ACT Plus/ICM receive Peer Support solely through their ACT/ACT Plus/ICM team.

Peer Specialists should not be involved in managing medications and should not generally be expected to perform tasks that other team members are trained to do.

Peer Specialists do not generally assist with ADLs.

Peer Specialists should be supervised by senior Peer Specialists or non-Peer Specialist staff that has been certified to supervise Peer Specialists and receive regularly scheduled clinical supervision from a person meeting the qualifications of a mental health professional with experience regarding this specialized Mental Health service. On an ACT or ICM team, this supervision would ideally be provided primarily by the Team Leader.

The Care Manager must ensure that the provider maintains documentation and that the Care Manager monitors the services on an ongoing basis to ensure that the health and welfare of the beneficiary is met, and the Recovery Plan goals are achieved. The documentation must be available to the Care Manager for monitoring at all times, on an ongoing basis. Documentation in accordance with DHSS requirements must be maintained in the beneficiary's file by the Care Manager and updated with each reauthorization, as applicable.

Provider Specifications

Provider Category(s) (check one or both):		Individual (list types):	X	Agency (list types):
			Peer Specialist Agency. SUD Treatment Program or a COD Treatment Program. ACT Team. ICM Team. ACT Plus Team. PROMISE Rehabilitation Agency.	

Specify Whether the Service May Be Provided By (check each that applies):	☐	Legally Responsible Person.	☐	Relative/Legal Guardian.

Provider Qualifications

Provider Type:	License (specify):	Certificate (specify):	Other Standard (specify):
Peer Specialist Agency.			• Designation by DSAMH as a qualified Peer Specialist Agency, including compliance with minimum State training requirements and other settlement requirements. • In compliance with State mandates under the settlement, Peer Specialist Agencies may provide any component of the services listed and must employ/contract and utilize the qualified HCBS providers necessary to maintain beneficiaries in the community, including Peer Specialists. • Peer Specialists in a Peer Specialist Agency must: – Be at least 21 years old. – Have a high school diploma or equivalent (preferably with some college background). – Be certified and registered in the State of Delaware to provide the service, which includes criminal, abuse/neglect

			registry and professional background checks, and completion of a State-approved standardized basic trainingprogram. – Self-identify as having lived experience of mental illnessand/or substance abuse as a present or former primary beneficiary or survivor of mental health and/or SUD services. – Have taken the State-approved standardized Peer Specialist training that includes academic information, as well as practical knowledge and creative activities focused on the principles and concepts of Peer Support and how it differs from clinical support. The training provides practical tools for promoting wellness and recovery, knowledge aboutbeneficiary rights and advocacy, as well as approaches to care that incorporate creativity.
SUD Treatment Program or a COD(SUD with mental health disorder) Treatment Program.	16 Del. Admin. C.§ 6001 et seq (DSAMH Substance Abuse Facility Licensing Standards).		• Peer Specialists in a SUD or COD Treatment Program must: – Be at least 21 years old. – Have a high school diploma or equivalent (preferably withsome college background). – Be certified and registered in the State of Delaware to provide the service, which includes criminal, abuse/neglectregistry and professional background checks, and completion of a State-approved standardized basic trainingprogram. – Self-identify as having lived experience of mental illnessand/or substance abuse as a present or former primary beneficiary or survivor of mental health and/or SUD services. – Have taken the State-approved standardized Peer Specialist training that includes academic information, as well as practical knowledge and creative activities focused on the principles and concepts of Peer Support and how it differs from clinical support. The training provides practical tools for promoting wellness and recovery, knowledge aboutbeneficiary rights and advocacy, as well as approaches to care that incorporate creativity.
ACT Team (including specialized SUD ACT team and ACT reintegration team).		Certification by DSAMH as an ACT team in fidelity with TMACT.	• In compliance with TMACT fidelity (scoring at least a 3.0) or having provisional certification, ACT teams may provide any component of the services listed and must employ and utilizethe qualified State Plan providers (i.e., Physicians, Licensed Practitioners) and HCBS providers necessary to maintain fidelity, including CPST specialists. • Peer Specialists on an ACT Team must: – Be at least 21 years old. – Have a high school diploma or equivalent (preferably withsome college background). – Be certified and registered in the State of Delaware to provide the service, which includes criminal, abuse/neglectregistry and professional background checks, and completion of a State-approved standardized basic trainingprogram. – Self-identify as having lived experience of mental illnessand/or substance abuse as a present or former primary

			beneficiary or survivor of mental health and/or SUD services. — Have taken the State-approved standardized Peer Specialist training that includes academic information, as well as practical knowledge and creative activities focused on the principles and concepts of Peer Support and how it differs from clinical support. The training provides practical tools for promoting wellness and recovery, knowledge about beneficiary rights and advocacy, as well as approaches to care that incorporate creativity. Additional ACT training required: • The ACT Peer Specialist is an individual who has a unique perspective because of his/her own experience with SPMI or a COD of SMI and SUD. Qualifications include: — An ability or aptitude to communicate peer/recovery skills, attitudes, and concepts to other members of the team. — Ability to work independently and collaboratively. — Peer Specialist training. — Willingness to self-disclose to beneficiaries and others, as appropriate. — Willingness to attend training on subjects of recovery. — Adequate transportation necessary to attend meetings, required training, and meet with clients. • The ACT Peer Specialist shall have documented competency in the following areas, or receive core training to be completed within six (6) months of hire: — Recovery from a mental condition or COD mental health and SUD condition that is self-expressed freely. — An ongoing self-recovery plan that the Peer Specialist can clearly articulate. — Experience in providing Peer Support services, as identified above. — Participation in local or national consumer advocacy organizations. — An understanding of psychiatric advance directives. — An ability or aptitude to communicate peer/recovery skills, attitudes, and concepts to other members of the team. — Education and advocacy. – Information and referral.
ICM Team.		Certification by DSAMH in fidelity with State ICM standards.	• In compliance with State mandates under the settlement, ICM teams may provide any component of the services listed and must employ and utilize the qualified State Plan providers (i.e., Physicians, Licensed Practitioners) and HCBS providers necessary to maintain fidelity, including Peer Specialists. ACT teams not meeting provisional certification or having fidelity below 3.0 are ICM teams. • Peer Specialists on an ICM Team must: — Be at least 21 years old. — Have a high school diploma or equivalent (preferably with some college background). — Be certified and registered in the State of Delaware to provide the service, which includes criminal, abuse/neglect registry and professional background checks, and

			completion of a State-approved standardized basic training program. – Self-identify as having lived experience of mental illness and/or substance abuse as a present or former primary beneficiary or survivor of mental health and/or SUD services. – Have taken the State-approved standardized Peer Specialist training that includes academic information, as well as practical knowledge and creative activities focused on the principles and concepts of Peer Support and how it differs from clinical support. The training provides practical tools for promoting wellness and recovery, knowledge about beneficiary rights and advocacy, as well as approaches to care that incorporate creativity. Additional ICM training required: • The ICM Peer Specialist is an individual who has a unique perspective because of his/her own experience with SPMI or a COD of SMI and SUD. Qualifications include: – An ability or aptitude to communicate peer/recovery skills, attitudes, and concepts to other members of the team. – Ability to work independently and collaboratively. – Peer Specialist training. – Willingness to self-disclose to beneficiaries and others, as appropriate. – Willingness to attend training on subjects of recovery. – Adequate transportation necessary to attend meetings, required training, and meet with clients. • The ICM Peer Specialist shall have documented competency in the following areas, or receive core training to be completed within six (6) months of hire: – Recovery from a mental condition or COD mental health and SUD condition that is self-expressed freely. – An ongoing self-recovery plan that the Peer Specialist can clearly articulate. – Experience in providing Peer Support services, as identified above. – Participation in local or national consumer advocacy organizations. – An understanding of psychiatric advance directives. – An ability or aptitude to communicate peer/recovery skills, attitudes, and concepts to other members of the team. – Education and advocacy. – Information and referral.
ACT Plus Team.			• Designation by DSAMH as a qualified ACT Plus Agency, includingcompliance with minimum State training requirements and othersettlement requirements. • In compliance with State mandates under the settlement, ACT Plus teams may provide any component of the services listed and must employ/contract and utilize the qualified HCBS providers necessary to maintain beneficiaries in the community, including Peer Specialists. • Peer Specialists in an ACT Plus Agency must: – Be at least 21 years old.

			– Have a high school diploma or equivalent (preferably with some college background). – Be certified and registered in the State of Delaware to provide the service, which includes criminal, abuse/neglect registry and professional background checks, and completion of a State-approved standardized basic training program. – Self-identify as having lived experience of mental illness and/or substance abuse as a present or former primary beneficiary or survivor of mental health and/or SUD services. – Have taken the State-approved standardized Peer Specialist training that includes academic information, as well as practical knowledge and creative activities focused on the principles and concepts of Peer Support and how it differs from clinical support. The training provides practical tools for promoting wellness and recovery, knowledge aboutbeneficiary rights and advocacy, as well as approaches to care that incorporate creativity.
PROMISE Rehabilitation Agency.			• Designation by DSAMH as a qualified PROMISE Rehabilitation Agency, including compliance with minimum State training requirements and other settlement requirements. • In compliance with State mandates under the settlement, PROMISE Rehabilitation Agencies may provide any component of the services listed and must employ/contract and utilize the qualified HCBS providers necessary to maintain beneficiaries in the community, including Peer Specialists. • Peer Specialists in a PROMISE Rehabilitation Agency must: — Be at least 21 years old. — Have a high school diploma or equivalent (preferably with some college background). — Be certified and registered in the State of Delaware to provide the service, which includes criminal, abuse/neglect registry and professional background checks, and completion of a State-approved standardized basic training program. — Self-identify as having lived experience of mental illness and/or substance abuse as a present or former primary beneficiary or survivor of mental health and/or SUD services. — Have taken the State-approved standardized Peer Specialist training that includes academic information, as well as practical knowledge and creative activities focused on the principles and concepts of Peer Support and how it differs from clinical support. The training provides practical tools for promoting wellness and recovery, knowledge about beneficiary rights and advocacy, as well as approaches to care that incorporate creativity.

Verification of Provider Qualifications:

Provider Type:	***Entity Responsible for Verification:***	***Frequency of Verification:***
Peer Specialist Agency.	DHSS or its designee.	Upon contracting, and at least bi-annually thereafter, DHSS will conduct and on-site audit to ensure that all providers are appropriately credentialed.

SUD Treatment Program or a COD (SUD with mental health disorder) Treatment Program.	DHSS or its designee	Upon contracting, and at least bi-annually thereafter, DHSS will conduct and on-site audit to ensure that all providers are appropriately credentialed.
ACT Team.	DHSS or its designee.	Upon contracting, and at least bi-annually thereafter, DHSS will conduct and on-site audit to ensure that all providers are appropriately credentialed.
ICM Team.	DHSS or its designee.	Upon contracting, and at least bi-annually thereafter, DHSS will conduct and on-site audit to ensure that all providers are appropriately credentialed.
ACT Plus Team.	DHSS or its designee.	Upon contracting, and at least bi-annually thereafter, DHSS will conduct and on-site audit to ensure that all providers are appropriately credentialed.
PROMISE Rehabilitation Agency.	DHSS or its designee	Upon contracting, and at least bi-annually thereafter, DHSS will conduct and on-site audit to ensure that all providers are appropriately credentialed.

Service Delivery Method				
Service Delivery Method (check each that applies):	☐	Participant-directed.	X	Provider Managed.

Billing Method	
Bill Code:	**Billing Rate and Unit:**
H0038: • Self-help/peer services, per 15 minutes. H0038 HQ: • Self-help/peer services, per 15 minutes. • HQ = group setting.	• $20.86 per 15 minutes. • $4.07 per 15 minutes.
Peer Support services provided by a Peer Specialist on an ACT or ICM team should refer to the CPST service section for appropriate ACT/ICM billing codes and rates for this service.	

Personal Care

Service Specification	
Service Title:	Personal Care
Service Definition (Scope):	

Personal Care includes care with ADLs (e.g., bathing, dressing, personal hygiene, transferring, toileting, skin care, eating, and assisting with mobility). When specified in the Recovery Plan, this service includes care with IADLs (e.g., light housekeeping, chores, shopping, meal preparation). Care with IADLs must be essential to the health and welfare of the beneficiary based on the assessment of the Care Manager and identified within the Recovery Plan as a goal that was identified by the beneficiary. Input should also be obtained from the beneficiary's family or other natural supports, when appropriate and desired by the beneficiary.

Personal Care services primarily provide hands-on Personal Care to beneficiaries that reside in a private home and that are necessary, as specified in the Recovery Plan, to enable the beneficiary to integrate more fully into the community and ensure the health, welfare, and safety of the beneficiary.

This service will be provided to meet the beneficiary's needs, as determined by an assessment, in accordance with DHSS requirements and as outlined in the beneficiary's Recovery Plan.

If there is more than one (1) staff member on site at the residence during normal hours who can provide Personal Care services, the provider and beneficiary will be encouraged to hire staff to deliver Personal Care services separate from staff who provide Habilitation services that involved the development of ADL and IADL skills. This will ensure that the clinical boundary issues that would otherwise complicate Habilitation services (if the same staff were also delivering Personal Care services) will be mitigated.

Personal Care services are aimed at assisting the beneficiary with completing ADLs that would be performed independently if they had no disability. These services include:

- Assisting with ADLs (e.g., eating, bathing, dressing, personal hygiene), cueing to prompt the beneficiary to perform a task, and providing supervision to assist a beneficiary who cannot be safely left alone.
- Health maintenance, such as bowel and bladder routines, ostomy care, catheter, wound care, and range of motion, as indicated in the beneficiary's Recovery Plan and permitted under applicable State requirements.
- Routine Support services, such as meal planning, keeping of medical appointments, and other health regimens needed to support the beneficiary.
- Care and implementation of prescribed therapies.
- Overnight Personal Care services to provide intermittent or ongoing awake, overnight care to a beneficiary in their home for up to eight (8) hours. Overnight Personal Care services require awake staff.

Personal Care may include care with the following activities when incidental to Personal Care and necessary to complete ADLs:

- Activities that are incidental to the delivery of the personal care to assure the health, welfare, and safety of the beneficiary, such as changing linens, doing the dishes associated with the preparation of a meal, and laundering towels from bathing may be provided and must not comprise the majority of the service.
- Services to accompany the beneficiary into the community for purposes related to Personal Care, such as shopping in a grocery store, picking up medications, and providing care with any of the activities noted above to enable the completion of those tasks.

Services must be delivered in a manner that supports the beneficiary's communication needs including, but not limited to, age-appropriate communication, translation/Interpretation services for beneficiaries that are of limited-English proficiency, or who have other communication needs requiring translation, and assistance with the provider's understanding and use of communication devices used by the beneficiary.

The Personal Care service provider must maintain documentation in accordance with DHSS requirements. The documentation must be available to the Care Manager for monitoring at all times on an ongoing basis. The Care Manager will monitor on a quarterly basis to see if the objectives and outcomes are being met.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Personal Care services may not be billed at the same time as Respite or IADL/Chore services.

Personal Care services are provided only during those times when neither the beneficiary nor anyone else in the household is able or available to provide them, and where no other relative, caregiver, community/volunteer agency, or third-party payer is able to provide, or be responsible for, their provision.

Personal Care services in excess of 12 hours per day will require prior approval by DHSS.

Additional medical necessity criteria for receiving the service, if applicable (specify):

Medical necessity criteria include the following:

- The service is recommended by the Care Manager and the beneficiary in collaboration, and the service is included in the beneficiary's Recovery Plan, AND
- The service is needed to allow the beneficiary the best opportunity to remain in the community, AND
- The tasks required are unable to be completed by the beneficiary or paid or unpaid caregiver, AND
- The beneficiary is not residing in a community-based Group Home, AND
- The frequency and intensity of the service aligns with the unique needs of the beneficiary (see examples below), AND
- For beneficiaries also enrolled in DSHP Plus, the Recovery Plan clearly identifies the types of services needed that are in addition to what is already being provided by DSHP Plus.

Examples of the need for Personal Care services include:

- A beneficiary has established a goal to engage in more social activities and to strengthen her social network of friends. However, she struggles with maintaining good personal hygiene due to lack of energy, focus, and poor self-hygiene. This negatively interferes with goals for social interaction and Personal Care has been identified as necessary to provide daily assistance with bathing, dressing, and personal hygiene.
- A beneficiary has the goal of living independently but struggles with debilitating and recurring nightmares that can trigger thoughts of self-harm. He believes overnight Personal Care services could offer the necessary support and supervision he needs to ensure his safety, while still allowing him to live in his own home.
- A beneficiary has a goal of preparing meals for herself regularly and for her friends a couple of times each month. She believes her preoccupation with germs/potential contamination interfere with her ability to shop for food and prepare meals. She has identified that Personal Care services, made available three (3) times per week to accompany her to the grocery store, and daily to assist her with meal preparation, would help her make significant progress in achieving her goal.

Except as permitted in accordance with requirements contained in DHSS 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. This service is not available to beneficiaries residing in Assisted Living or receiving Residential Alternatives. Personal Care services may only be on the same Recovery Plan as Assisted Living or Residential Alternatives in limited circumstances, as approved by DHSS, such as Personal Care necessary to support a beneficiary in a work environment.

Costs incurred by the Personal Care service workers that relate to accompanying a beneficiary in the community or accessing other services are not reimbursable under the waiver as Personal Care services (e.g., tickets to a movie or ball game). The transportation costs associated with the provision of Personal Care outside the beneficiary's home must be billed separately and may not be included in the scope of Personal Care. Personal Care workers may furnish and bill separately for Transportation provided they meet the State's provider qualifications for Transportation services, whether Medical Transportation under the State Plan or NMT under the waiver.

To the extent that integration into the community and recover-oriented goals are the primary focus of the activity provided, the beneficiary and Care Manager may want to utilize Peer Support resources on the Recovery Plan instead of Personal Care. If the goals are solely Personal Care in nature, Peers Support should not be utilized to provide the service.

The Care Manager must ensure that the provider maintains documentation and that the Care Manager monitors the services on an ongoing basis to ensure that the health and welfare of the beneficiary is met, and the Recovery Plan goals are achieved. The documentation must be available to the Care Manager for monitoring at all times, on an ongoing basis. Documentation in accordance with DHSS requirements must

be maintained in the beneficiary's file by the Care Manager and updated with each reauthorization, as applicable.

Provider Specifications				
Provider Category(s) (check one or both):	☐	Individual (list types):	X	Agency (list types):
				Home Health Agency. Personal Assistance Services Agency.
Specify whether the service may be provided by (check each that applies):	☐	Legally Responsible Person.	☐	Relative/Legal Guardian.

Provider Qualifications			
Provider Type:	**License (specify):**	**Certificate (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 DHSS standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. • Ensure employees and/or contractors complete DHSS-required training, including training on the beneficiary's Recovery Plan and the beneficiary's unique and/or disability-specific needs, which may include, but are not limited to, communication, mobility, and behavioral needs. • Individuals employed by a Home Health Agency 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, 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 finding in the performance of the service. – In the case of Direct Care personnel, possess certification through successful completion of training program, as required by DHSS.
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 DHSS standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. • Ensure employees and/or contractors complete DHSS-required training, including training on the beneficiary's Recovery Plan and the beneficiary's unique and/or disability-specific needs, which may include, but are not limited to, communication, mobility, and behavioral needs. • Individuals employed by a Personal Assistance Services Agency 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, 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 finding in the performance of the service. – In the case of Direct Care personnel, possess certification through successful completion of training program as required by DHSS.

Verification of Provider Qualifications:		
Provider Type:	***Entity Responsible for Verification:***	***Frequency of Verification:***
Home Health Agency.	DHSS or Designee.	Initially and annually (or more frequently, based on service monitoring concerns).
Personal Assistance Services Agency.	DHSS or Designee.	Initially and annually (or more frequently, based on service monitoring concerns).

Service Delivery Method				
Service Delivery Method (check each that applies):	☐	Participant-directed.	X	Provider managed.

Billing Method	
Bill Code:	**Billing Rate and Unit:**
T1019: • Personal Care services, per 15 minutes; not for an Inpatient or Resident of a Hospital, Nursing Facility, ICF/MR or IMD; part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or CNA); Home Health Agency. T1019 U1: • Personal Care services, per 15 minutes; not for an Inpatient or Resident of a Hospital, Nursing Facility, ICF/MR or IMD; part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or CNA); Personal Care Agency.	• Home Health Agency: $8.00 per 15 minutes. • Personal Assistance Agency: $5.85 per 15 minutes.

Psychosocial Rehabilitation

Service Specification	
Service Title:	Psychosocial Rehabilitation (PSR)

Service Definition (Scope):

PSR services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid-eligible adults with significant functional impairments meeting the need levels in the PROMISE program resulting from an identified mental health or SUD diagnosis. The medical necessity for these Rehabilitative services must be determined by a LBHP or Physician, who is acting within the scope of his/her professional license and applicable State law and furnished by or under the direction of a Licensed Practitioner, to promote the maximum reduction of symptoms and/or restoration of a beneficiary to his/her best age-appropriate functional level conducting an assessment consistent with State law, regulation, and policy. A unit of service is defined according to the HCPCS approved code set unless otherwise specified.

Definitions

PSR services are designed to assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness and/or SUD. Activities included must be intended to achieve the identified goals or objectives as set forth in the beneficiary's Recovery Plan. The intent of PSR is to restore the fullest possible integration of the beneficiary as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention. PSR is a face-to-face intervention with the beneficiary present. Services may be provided individually or in a group setting and should utilize (with documentation) evidence-based rehabilitation interventions. Group PSR sessions may not include more than eight (8) beneficiaries in attendance. This service may include the following components:

- 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 effective functioning in the beneficiary's social environment including home, work, and school.
- Restoration, rehabilitation, and support with the development of daily living skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a beneficiary's daily living. Supporting the beneficiary with development and implementation of daily living skills and daily routines critical to remaining in home, school, work, and community.
- Assisting the beneficiary with implementing learned skills so he/she can remain in a natural community location.
- Assisting the beneficiary with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.
- Ongoing in-vivo assessment of the beneficiary's functional skill and impairment levels that is used to select PSR interventions and periodically assess their effectiveness. Workers who provide PSR services should periodically report to a supervising Licensed Practitioner on beneficiaries' progress toward the recovery and re-acquisition of skills.

Additional medical necessity criteria for receiving the service, if applicable (specify):

For beneficiaries not receiving ACT/ICM, medical necessity criteria includes the following:

- The service is recommended by a LBHP or Physician acting within the scope of his/her professional license, AND
- The service is included in the beneficiary's Recovery Plan, AND
- The service is needed to allow the beneficiary the best opportunity to remain in the community, AND
- The service is directed at developing skills or achieving specific outcome(s) such as: increasing community tenure/inclusion/participation, enhancing personal relationships; establishing support networks; increasing independence/productivity; developing daily living skills to improve self-management of the effects of psychiatric or emotional symptoms that interfere with daily living; effectively responding to or avoiding identified precursors or triggers that result in functional impairments; increasing or maintaining personal self-sufficiency; and/or developing coping strategies and effective functioning in the social environment, including home, work and school, AND

- The beneficiary requires involvement of a LBHP to help develop and achieve these outcomes, AND
- The frequency and intensity of the service aligns with the unique needs of the beneficiary. Examples include:
  - A beneficiary being discharged from an inpatient setting after three (3) admissions in six (6) months has a goal of being able to better self-manage the ongoing symptoms of his mental illness and identifies the need for 10 hours per week of PSR for the next three (3) months to help him practice new coping strategies when he is feeling stressed or anxious, and to assist him with developing more effective daily living skills to prevent unnecessary anxiety, such as time management, budgeting, and timely payment of monthly bills.
  - A beneficiary identifies group PSR sessions as a way to help her achieve her goals of establishing a support network and learning how to better self-manage her ongoing symptoms of Bipolar Disorder. PSR is requested once a week for six (6) months.

For beneficiaries receiving ACT, medical necessity criteria includes the following:

- ACT admission criteria (see Appendix 1 Section 1.1 for a complete listing of admission criteria)
  - Must be certified by the Psychiatric prescriber.
  - SPMI that seriously impairs a beneficiary's ability to live in the community.
  - Priority is for beneficiaries with Schizophrenia, other psychotic disorders, Bipolar Disorder.
  - Must have primary mental health diagnosis or COD.
  - Beneficiaries with only SUD/IDD, brain injury, or personality disorder **are not intended recipients.**
  - May have repeated hospitalizations with SUD issues.
  - Must have at least one of the following (#'s 1-4):
    - Difficulty performing daily tasks for basic adult functioning in the community (e.g., personal business; obtaining medical, legal, and housing services; recognizing and avoiding common dangers to self and possessions; meeting nutritional needs; maintaining personal hygiene).
    - Significant difficulty maintaining consistent employment at a self-sustaining level, or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks).
    - Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).
    - High use of Acute Hospitals (two (2) or more admissions per year) or Psychiatric Emergency services.
    - Intractable (persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).
    - Co-occurring substance use and SPMI or SMI of significant duration (e.g., greater than six (6) months).
    - High risk or recent history of criminal justice involvement (e.g., arrest and incarceration).
    - Significant difficulty meeting basic survival needs, residing in substandard housing, homeless, or at imminent risk of becoming homeless.
    - Residing in an Inpatient or Supervised Community Residence, but clinically assessed to be able to live in a more independent living situation if Intensive services are provided, or requiring a Residential or Institutional placement if more Intensive services are not available.
    - Difficulty effectively utilizing traditional office-based Outpatient services or other less-intensive community-based programs (e.g., beneficiary fails to progress, drops out of services).
- Admission documentation must include:
  - Evidence that one of the criteria is met.
  - The reasons for admission are stated by BOTH the beneficiary and ACT team.
  - Signature of the Psychiatric prescriber.
  - Engagement/enrollment into ACT must begin within five (5) days of referral to ACT.
  - A review of medical necessity can be initiated at any time, but treatment team notes must regularly reflect all life domains and ongoing medical necessity of services.
- ACT discharge criteria:
  - Minimum of four (4) hours of services per month.

- If fewer than four (4) hours is provided during the course of six (6) months due to recovery progress, the level of care must be evaluated.
- Changes in Recovery Plan goals.
- Plans for continuing care in the next month.

For beneficiaries receiving ICM, medical necessity criteria includes the following:

- ICM admission criteria (see Appendix 2 Section 3.1 for a complete listing of admission criteria)
  - Must be certified by the Psychiatric prescriber.
  - SPMI that seriously impairs a beneficiary's ability to live in the community.
  - Priority is for beneficiaries with Schizophrenia, other psychotic disorders, Bipolar Disorder.
  - Must have primary mental health diagnosis or COD.
  - Beneficiaries with only SUD/IDD, brain injury, or personality disorder **are not intended recipients.**
  - May have repeated hospitalizations with SUD issues.
  - Diagnoses that would otherwise be excluded from ICM services may be considered for an ICM team if an assessment by the team supports ICM services as the best course of action.
  - Must have at least one of the following (#'s 1-4):
    - Difficulty performing daily tasks for basic adult functioning in the community (e.g., personal business; obtaining medical, legal, and housing services; recognizing and avoiding common dangers to self and possessions; meeting nutritional needs; maintaining personal hygiene).
    - Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks).
    - Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).
    - Continuous high service needs as demonstrated by at least one of the following:
      - Co-occurring substance use and SPMI or SMI of significant duration (e.g., greater than six (6) months).
      - High risk or recent history of criminal justice involvement (e.g., arrest and incarceration).
      - Difficulty effectively utilizing traditional office-based Outpatient services or other less-intensive community-based programs (e.g., beneficiary fails to progress, drops out of services).
- ICM discharge criteria:
  - Requests for discharge from services shall occur when a beneficiary:
    - Has successfully reached individually established goals (i.e., demonstrates an ability to function in all major role areas such as work, social, self-care) for discharge, and when the beneficiary and program staff mutually agrees to the transition to less intensive services).
    - Moves outside the geographic area of ICM responsibility. In such cases, the ICM team shall arrange for transfer of Mental Health service responsibility to an ACT or ICM program or another provider wherever the beneficiary is moving. The ICM team shall maintain contact with the beneficiary until this service transfer is complete.
    - Declines or refuses services and requests discharge despite the team's documented best efforts to utilize appropriate engagement techniques to develop a mutually acceptable participant-directed Recovery Plan with the beneficiary:
      - Prior to discharge from ICM services, the EEU shall approve and/or request further information to review the circumstances, clinical situation, risk factors, and attempted strategies to engage the beneficiary.
  - In addition to the discharge criteria listed above, based on mutual agreement within the ICM team, a beneficiary discharge may also be facilitated due to any one of the following circumstances:
    - Death.
    - Inability to locate the beneficiary despite documented active outreach efforts by the team for a period of 90 continuous days.
    - Incarceration of 90 days or more.

	– Hospitalization or Nursing Facility care where it has been determined, based on mutual agreement by the Hospital or Nursing Facility treatment team and the ICM team, with approval by the EEU, that the beneficiary will not be appropriate for discharge from the Hospital or Nursing Facility for a prolonged period of time.
Specify limits (if any) on the amount, duration, or scope of this service for (chose each that applies):	
X	***Categorically needy (specify limits):***
	PSR Limitations Services are subject to prior approval, must be medically necessary, and must be recommended by a LBHP or Physician according to a Recovery Plan. The activities included in the service must be intended to achieve identified Recovery Plan goals or objectives. The Recovery 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 these specific Rehabilitative services. The Recovery Plan should identify the Medical or Remedial services intended to reduce the identified condition, as well as the anticipated outcomes of the beneficiary. The Recovery Plan must specify the frequency, amount, and duration of services. The Recovery Plan must be signed by the LBHP or Physician responsible for developing the plan. The Recovery 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 Recovery Plan should be developed if there is no measurable reduction of disability or restoration of functional level. The new Recovery Plan should identify different rehabilitation strategy with revised goals and services. Providers must maintain case records that include a copy of the Recovery 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 Recovery Plan. Services provided at a work site must not be job tasks oriented and must not duplicate any Individual or Short-term Group Supported Employment. Any services or components of services which are to supplant housekeeping, homemaking, or basic services for the convenience of a beneficiary receiving covered services (including housekeeping, shopping, childcare, and laundry services) are non-covered. Services cannot be provided in an IMD. Room and Board is excluded. PSR interventions chosen must have a proven evidence-based support for their effectiveness. EBPs require prior approval and fidelity reviews on an ongoing basis, as determined necessary by DHSS. Services may be provided at a site-based facility, in the community, or in the beneficiary's place of residence, as outlined in the Recovery Plan. Components that are not provided to, or directed exclusively toward the treatment of, the Medicaid-eligible beneficiary are not eligible for Medicaid reimbursement. Limit of 260 hours of group PSR per calendar year. This limit can be exceeded when medically necessary through prior authorization. The PSR provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a LBHP with experience regarding this specialized Mental Health service. Beneficiaries enrolled in ACT/ACT Plus/ICM receive PSR solely through their ACT/ACT Plus/ICM team. The Care Manager must ensure that the provider maintains documentation and that the Care Manager monitors the services on an ongoing basis to ensure that the health and welfare of the beneficiary is met, and the Recovery Plan goals are achieved. The documentation must be availableto the Care Manager for monitoring at all times, on an ongoing basis. Documentation in accordancewith DHSS requirements must be maintained in the beneficiary's file by the Care Manager and updated with each reauthorization, as applicable.
☐	***Medically needy (specify limits):***

Specify whether the service may be provided by a (check each that applies):	☐	Relative.
	☐	Legal Guardian.
	☐	Legally Responsible Person.

Provider Qualifications			
Provider Type (Specify):	**License (Specify):**	**Certification (Specify):**	**Other Standard (Specify):**
SUD Treatment Program or a COD (SUD with mental health disorder) Treatment Program.	16 Del. Admin. C.§ 6001 et seq (Division of Substance Abuse and Mental Health Substance Abuse Facility Licensing Standards).		• PSR Specialists in a SUD or COD Treatment Program must: — Be at least 18 years old. — Meet the regulatory requirements for Associate Clinicians, such as a person with a bachelor's degree in a human service field or a RN. — Be certified in the State of Delaware to provide the service, which includes criminal, abuse/neglect registry, and professional background checks, and completion of a State approved standardized basic training program. • Anyone providing SUD services must be certified by DHSS, in addition to any required scope of practice license required for the facility or agency to practice in the State.
ACT Team (including specialized SUD ACT team and ACT reintegration team).		Certification by DSAMH as an ACT team in fidelity with TMACT.	• In compliance with TMACT fidelity (scoring at least a 3.0) or having provisional certification, ACT teams may provide any component of the services listed and must employ and utilize the qualified State Plan providers (i.e., Physicians, Licensed Practitioners) and HCBS providers necessary to maintain fidelity, including CPST specialists. • PSR Specialists on an ACT Team must: — Be at least 18 years old. — Meet the regulatory requirements for Associate Clinicians, such as a person with a bachelor's degree in a human service field or a RN. — Be certified in the State of Delaware to provide the service, which includes criminal, abuse/neglect registry, and professional background checks, and completion of a State approved standardized basic training program. • Anyone providing SUD services must be certified by DHSS, in addition to any required scope of practice license required for the facility or agency to practice in the State.
ICM Team.		Certification by DSAMH in fidelity with State ICM standards.	• In compliance with State mandates under the settlement, ICM teams may provide any component of the services listed and must employ and utilize the qualified State Plan providers (i.e., Physicians, Licensed Practitioners) and HCBS providers necessary to maintain fidelity, including PSR specialists. ACT teams not meeting provisional certification or having fidelity below 3.0 are ICM teams. • PSR Specialists on an ICM team must: — Be at least 18 years old. — Meet the regulatory requirements for Associate Clinicians, such as a person with a bachelor's degree in a human service field or a RN.

			— Be certified in the State of Delaware to provide the service, which includes criminal, abuse/neglect registry, and professional background checks, and completion of a State approved standardized basic training program. • Anyone providing SUD services must be certified by DHSS, in addition to any required scope of practice license required for the facility or agency to practice in the State.
ACT Plus Team.			• Designation by DSAMH as a qualified ACT Plus agency,including compliance with minimum State training requirements and other settlement requirements. • In compliance with State mandates under the settlement, ACT Plus teams may provide any component of the services listed and must employ/contract and utilize the qualified HCBS providers necessary to maintain beneficiaries in the community, including PSRSpecialists. • PSR Specialists in an ACT Plus Team must: — Be at least 18 years old. — Meet the regulatory requirements for Associate Clinicians such as a person with a bachelor's degree in a human service field or a RN. — Be certified in the State of Delaware to provide the service, which includes criminal, abuse/neglect registry, and professional background checks, and completion of a State approved standardized basic training program. • Anyone providing SUD services must be certified by DHSS, in addition to any required scope of practice license required for the facility or agency to practice in the State.
PROMISE Rehabilitation Agency.			• Designation by DSAMH as a qualified PROMISE Rehabilitation agency, including compliance with minimum State training requirements and other settlement requirements. • In compliance with State mandates under the settlement, PROMISE Rehabilitation Agencies may provide any component of the services listed and must employ/contract and utilize the qualified HCBS providers necessary to maintain beneficiaries in the community, including PSR Specialists. • PSR Specialists in a PROMISE Rehabilitation Agency must: — Be at least 18 years old. — Meet the regulatory requirements for Associate Clinicians such as a person with a bachelor's degree in a human service field or a RN. — Be certified in the State of Delaware to provide the service, which includes criminal, abuse/neglect registry, and professional background checks, and completion of a State approved standardized basic training program.

			• Anyone providing SUD services must be certified by DHSS, in addition to any required scope of practice license required for the facility or agency to practice in the State.

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):***
SUD Treatment Program or a COD (SUD with mental health disorder) Treatment Program.	DHSS or its designee.	Upon contracting, and at least bi-annually thereafter, DHSS will conduct and on-site audit to ensure that allproviders are appropriately credentialed.
ACT Team.	DHSS or its designee.	Upon contracting, and at least bi-annually thereafter, DHSS will conduct and on-site audit to ensure that allproviders are appropriately credentialed.
ICM Team.	DHSS or its designee.	Upon contracting, and at least bi-annually thereafter, DHSS will conduct and on-site audit to ensure that allproviders are appropriately credentialed.
ACT Plus Team.	DHSS or its designee.	Upon contracting, and at least bi-annually thereafter, DHSS will conduct and on-site audit to ensure that allproviders are appropriately credentialed.
PROMISE Rehabilitation Agency.	DHSS or its designee.	Upon contracting, and at least bi-annually thereafter, DHSS will conduct and on-site audit to ensure that allproviders are appropriately credentialed.

Service Delivery Method				
Service Delivery Method (check each that applies):	☐	Participant-directed.	X	Provider managed.

Billing Method	
Bill Code:	**Billing Rate and Unit:**
H2017 HN: • PSR Services, per 15 minutes. • HN = Bachelor's level. H2017 HN HQ: • PSR Services, per 15 minutes. • HN = Bachelor's level. • HQ = Group Setting. H2017 HN U1 • PSR Services, per 15 minutes. • HN = Bachelor's level. • U1 = Medicaid level of care 1, services rendered in a home and community-based setting.	• Office Individual (1:1): $16.64 per 15 minutes. • Office Group (1:8): $4.16 per 15 minutes. • Community Individual (1:1): $18.40 per 15 minutes.
PSR services provided by a PSR Specialist on an ACT or ICM team should refer to the CPST service section of this manual for appropriate ACT/ICM billing codes and rates for this service.	

Respite

Service Specification	
Service Title:	Respite
Service Definition (Scope):	
Respite includes services provided to beneficiaries unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the beneficiary. Respite may be provided in an emergency to prevent hospitalization. Respite provides planned or emergency short-term relief to a beneficiary's unpaid caregiver or principal caregiver who is unavailable to provide support. This service will be provided to meet the beneficiary's needs as determined by an assessment performed in accordance with DHSS requirements, and as outlined in the beneficiary's Recovery Plan. Beneficiaries are encouraged to receive Respite in the most integrated and cost-effective settings appropriate to meet their Respite needs. Respite services may include the following activities: • Assistance with the beneficiary's social interaction, use of natural supports and typical community services available to all people, and participation in volunteer activities. • Activities to improve the beneficiary's capacity to perform or assist with ADLs and IADLs. • On site modeling of behavior, behavior support, intensive behavior episode intervention, training, cueing, and/or supervision. <u>Respite 15-minute Unit</u> Respite (15-minute unit) may be provided in the beneficiary's home or out of the beneficiary's home (not in a facility) in units of 15-minutes, for up to 12 hours a day. It is intended to provide short-term Respite. <u>Respite Per Diem</u> Respite (per diem) may be provided in a facility on a per diem basis. It is intended to provide short-term Respite. Services must be delivered in a manner that supports the beneficiary's communication needs including, but not limited to, age-appropriate communication, translation/Interpretation services for beneficiaries that are oflimited-English proficiency, or who have other communication needs requiring translation, and assistance with the provider's understanding and use of communication devices used by the beneficiary. If the beneficiary is to receive respite on an ongoing basis, the Care Manager will monitor on a quarterly basis, as applicable, to see if the objectives and outcomes are being met.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Respite services may not be billed at the same time as Personal Care or IADL/Chore services. This service is limited to no more than 14 days per year, regardless of funding source. DHSS may authorize service request expectations above these limits on a case-by-case basis when it is determined that: • No other service options are available to the beneficiary, including services provided through an informal support network. • The absence of the service would present a significant health and welfare risk to the beneficiary. • Respite service provided in a Nursing Home, Group Home, or Assisted Living facilities is not utilized to replace or relocate a beneficiary's primary residence. • Room and Board in a Nursing Facility and Group Home may be paid for by Medicaid for Respite service only.	
Additional medical necessity criteria for receiving the service, if applicable (specify):	
• The service is recommended by the Care Manager and the beneficiary in collaboration, and the service is included in the beneficiary's Recovery Plan, AND • There are emotional and/or behavioral problems which stress the ability of the caregiver or beneficiary to provide for the beneficiary's needs in the home thus putting the beneficiary at risk of requiring a more intensive level of care (e.g., strained family relationships, exhaustion in caregiver, caregiver struggles to meet other work/family responsibilities or lacks enough time to care for self needs, increased symptoms of mental illness or substance use, such as psychotic thinking, sleeplessness, or self-injurious behavior) OR the primary caregiver has a time limited situation that necessitates assistance in providing care for	

the beneficiary (e.g., caregiver is experiencing an acute medical problem, caregiver must attend to a family crisis), AND

- The absence of the service would present a significant health and welfare risk to the beneficiary (e.g., beneficiary has a seizure disorder, beneficiary needs assistance with medication administration, beneficiary has difficulty appropriately regulating water intake),
- No other means of temporary care exists, AND
- For beneficiaries also enrolled in DSHP Plus, the Recovery Plan clearly identifies the types of services needed that are in addition to what is already being provided by DSHP Plus, AND
- The frequency and intensity of the service aligns with the unique situation of the beneficiary and/or caregiver. Examples include:
  - A caregiver requests Respite for a particular weekend so he can have a break and visit family members out of State.
  - A beneficiary has a goal on her Recovery Plan to appropriately limit her water intake, since it has led to electrolyte imbalances numerous times in the past, and agrees that she continues to need support in order to achieve that goal. As a result, she and her sister (who she lives with) have identified the need for pre-planned Respite services one (1) afternoon each month so the sister can go to a movie or shopping alone.
  - A caregiver has identified the immediate need for Respite services for up to a week because the beneficiary has been awake most of the night for the last three (3) nights, resulting in the caregiver being awake as well and unable to go to work. The caregiver believes the beneficiary's mood and sleep cycle will normalize in about a week, as it has done many times before, but Respite will allow the beneficiary to avoid a higher level of care and will provide a needed break for the caregiver.

The Care Manager must ensure that the provider maintains documentation and that the Care Manager monitors the services on an ongoing basis to ensure that the health and welfare of the beneficiary is met, and the Recovery Plan goals are achieved. The documentation must be available to the Care Manager for monitoring at all times, on an ongoing basis. Documentation in accordance with DHSS requirements must be maintained in the beneficiary's file by the Care Manager and updated with each reauthorization, as applicable.

Provider Specifications

Provider Category(s) (check one or both):	☐	Individual (list types):	X	Agency (list types): Home Health Agency. Personal Assistance Agency. Nursing Facility. Group Home for Persons with Mental Illness.
Specify whether the service may be provided by (check each that applies):	☐	Legally Responsible Person.	☐	Relative/Legal Guardian.

Provider Qualifications

Provider Type:	License (specify):	Certificate (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	N/A.	• Comply with DHSS standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. • Ensure employees and/or contractors complete DHSS-required training, including training on the beneficiary's Recovery Plan and the beneficiary's unique and/or disability-specific needs, which mayinclude, but are not limited to, communication, mobility, and behavioral needs. • Individuals employed by a Home Health Agency must: — Be at least 18 years of age.

	Title 16-4406 Home Health Agencies (Licensure).		– Have criminal background investigations in accordance with State requirements. – Have a screening against the child abuse and adult abuse registry checks, 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 finding in the performance of the service. – In the case of Direct Care personnel, possess certification through successful completion of training program, as required by DHSS.
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 DHSS standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. • Ensure employees and/or contractors complete DHSS-required training, including training on the beneficiary's Recovery Plan and the beneficiary's unique and/or disability-specific needs, which may include, but are not limited to, communication, mobility, and behavioral needs. • Individuals employed by a Personal Assistance Services Agency 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, 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 finding in the performance of the service. – In the case of Direct Care personnel, possess certification through successful completion of training program, as required by DHSS.
Nursing Home.	State Business license or 501(c)(3) status and Delaware Skilled & Intermediate Care Nursing Facilities License as noted in Delaware Regulations Title 16, 3201.		
Group Home for Persons with Mental Illness.	Licensed by the Division of Long-Term Care under DAC Title 16, Chapter 11, Regulation 3305.		<u>5–10 Beds</u> The Agency must maintain a staffing ratio consistent with the weighted tiers of the clients in the home as outlined in the Community-based Residential Alternatives PROMISE service definition. The staff must meet the following qualifications and training: • Psychiatrist — A person with a medical degree or Doctor of Osteopathy degree, who is licensed to practice medicine in Delaware and is board certified in

			psychiatry or has served a residency in psychiatry. An LIP, such as a Nurse Practitioner or Physician's Assistant, may work in this role under formal protocols with the Psychiatrist. • Clinician — A person with a doctoral or master's degree in clinical or counseling psychology, mental health nursing, clinical social work, vocational/psychiatric rehabilitation or education from an accredited college or university; a registered nurse with certification in mental health nursing from the American Nurses Association; or a person with a bachelor's degree with five (5) years' experience in mental health service delivery with at least two (2) years' experience in residential services. • Associate Clinician — A person with a bachelor's degree in clinical or counseling psychology, social work, nursing, vocational/psychiatric rehabilitation, education or other mental health field from an accredited college or university; or a registered nurse. An Associate Clinician shall have had at least two (2) years of direct experience in mental health service. • Residence Manager — Responsible for the operation of the Group Home and responsible for the supervision of beneficiaries' recovery plans. The qualifications of the Residence Manager must be that of a Clinician (see above). • Peer Specialist — A person with a lived experience of mental illness who has received training in this role and scope of practice. All Peer Specialists are certified by the State. • Residential Service Assistant — A person who has a high school diploma or equivalent or CNA. (Note: Residential Service Assistants are not permitted to meet staffing qualifications for Tier 4). **Note: Associate Clinicians and Residential Service Assistants shall have qualifications for the treatment activities in which they engage and shall be supervised by the Residence Manager. At least 75% of the Group Home staff shall be Clinicians or Associate Clinicians. 25% should be Peers who work as full members of the multi-disciplinary team. Nothing in these regulations shall be construed to exempt or limit the application of professional licensing requirements, including those pertaining to Professional Counselors, Psychologists, and Clinical Social Workers under 24 Del.C., Chs. 30, 35, and 39, respectively.* ***Note: Nothing in these regulations prohibit a Peer from serving in any of these roles if they also meet the role standards for education and years of experience.* • Accreditation is required for Group Homes with revenues over $500,000. • The service provider shall comply with criminal background check and drug testing laws.

			• The service provider shall maintain a current personnel policies and procedures manual that sets forth grounds for termination, adequately supports sound resident care and is made readily available to the program's staff in each home. The service provider shall comply with the provisions of such manual. The manual shall contain an explanation of the beneficiaries' rights pursuant to 16 Del.C. §1121 and applicable federal law: – Training in risk assessment of dangerousness and interventions aimed at reducing such risk, including training in managing difficult behaviors, in the implementation of de-escalation techniques, and in self-defense techniques to prevent harm from violent behaviors. – Orientation to situational counseling, stress management, and social interaction. – A complete course in medications used in the treatment of mental illness, including the medications' effects, side effects, and adverse effects (sometimes life threatening) used alone or in combination with other prescription and non-prescription medication and alcoholic or caffeinated beverages. – A course in the common types of mental illness. including signs and symptoms of Schizophrenia, mood and personality disorders, and indications of deterioration of a beneficiary's mental condition. – A course in basic first aid, including basic CPR training and basic physical health coaching including healthy diets, adequate exercise, smoking cessation, and routine dental and medical exams and services, as needed. – An explanation of the rights of adults with psychiatric disabilities in Residential Care in Delaware. – Expectations for confidentiality and ethical behavior towards beneficiaries who will reside in the Group Home. – Policies and procedures that apply to a Group Home on both a daily and emergency basis. – Fire safety and evacuation procedures. – Health care, sanitation, and safe handling of food. – Familiarization with Community Behavioral Health services available in the county in which the Group Home is located. – Orientation to situational counseling, de-escalation and mediation techniques, stress management, and social interaction. – Training in understanding what recovery actually looks like in terms of outcomes, avoidance of paternalistic approaches, how to support appropriate adult activities, and leisure skill development for beneficiaries.

			– Demonstration of a clear understanding of theseregulations. – A plan for the continuing education anddevelopment of staff. – A service provider need not require training in discrete areas in which the staff person has demonstrated competency through satisfactory jobperformance or previous experience to the satisfaction of the service provider and DHSS. – Staff may be provisionally hired and perform job duties pending completion of training within thirty (30) days. Such provisional staff shall not be on duty without on-site supervision.
Supportive Housing Agency.		Certification by DSAMH.	• The agency must maintain a staffing ratio consistent with the weighted tiers of the clients in the Supervised Apartments. The staff must meet the qualifications andtraining below: – Comply with DHSS standards, including regulations, contract requirements, policies, andprocedures relating to provider qualifications. – Have a waiver provider agreement. – The organization must be able to document three (3) years of experience in providing services to an SPMI population. – Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet theunique needs of the beneficiary (e.g., communication, mobility, and behavioral needs). – Comply with and meet all standards as appliedthrough each phase of the standard, annual DHSS-performed monitoring process. – Ensure 24-hour access to personnel (via direct employees or a contract) for response to emergency situations that are related to the Community-based Residential Alternatives serviceor other waiver services. • Employees must: – Be at least 18 years old. – Have a high school diploma or equivalent. – Have a valid driver’s license if the operation of avehicle is necessary to provide the service. – Be certified in the State of Delaware to provide theservice, which includes criminal, abuse/neglect registry, and professional background checks, andcompletion of a State approved standardized basictraining program. – If providing Nursing Care, must have qualificationsrequired under State Nurse Practice Act (i.e., RN or LPN). • All Supervised Apartment staff must complete thefollowing State-mandated training: – CPR. – First Aid.

			– Introduction to Community-Based Residential Services for Direct Care Staff. – Air and Blood Borne Pathogens. – Non-Physical Crisis De-Escalation, Crisis Management, and Debriefing. – Proper Techniques to Address Challenging Behavior and Proper Contingency Management. – Principles of Psychiatric Rehabilitation. – Motivational Interviewing for CODs. – Basics of Counseling. – Recovery Oriented Service Delivery & Documentation. – What is Peer Support? – Rights and Responsibilities of Beneficiaries Receiving Mental Health Services. – Cultural Competence and Diversity. – Prevention/Intervention and Recovery/Resiliency Strategies. – Behavioral Health/SUDs and Associated Medical Care and Conditions. – HIPPA and Confidentiality. – Grief, Loss, and Death Notification Procedures. – Applied Suicide Intervention Skills. – Community Integration and Olmstead Decision – Intro to Human Needs, Values, Guiding Principles, and Effective Teaching Strategies. – Environmental Emergencies: Mitigation, Preparation, and Responding. – Basic Health and Medications. – Advanced Health and Medications. – Nutrition: Food Preparation, Food Storage, Healthy Diet, and Positive Health. – Assessing mobile Crisis Need

Verification of Provider Qualifications:		
Provider Type:	***Entity Responsible for Verification:***	***Frequency of Verification:***
Home Health Agency.	DHSS or Designee.	Initially and annually (or more frequently, based on service monitoring concerns).
Personal Assistance Services Agency.	DHSS or Designee.	Initially and annually (or more frequently, based on service monitoring concerns).
Nursing Facility.	DHSS or Designee.	Initially and annually (or more frequently, based on service monitoring concerns).
Group Homes for Persons with Mental Illness Supportive Housing Agency.	DHSS or designee.	At least every two (2) years, and more frequently when deemed necessary by DHSS.

Service Delivery Method				
Service Delivery Method (check each that applies):	☐	Participant-directed.	X	Provider managed.

Billing Method	
Bill Code:	**Billing Rate and Unit:**
S5150: • Unskilled Respite, not Hospice, 15 minutes.	• Home Health Agency: $6.58 per 15 minutes. • Personal Assistance Agency: $5.85 per 15 minutes.
T2033: • Residential care, NOS, waiver, per diem, Tier 1.	Respite in Supervised Apartment Tier 1, per diem: • Tier 1 (non-ACT): $74.02.
T2033 TF: • Residential care, NOS, waiver, per diem, Tier 2. • TF = Intermediate level of care. T2033 TF UJ: • UJ = Services provided at night.	Respite in Supervised Apartment Tier 2, per diem: • Tier 2 Day (non-ACT): $53.23. • Tier 2 Night: $40.76.
T2033 TG: • Residential care, NOS, waiver, per diem, Tier 3. • TG = Complex/high-tech level of care.	Respite in Group Home Tier 3, per diem: • Tier 3: up to 5 residents in a Group Home: $328.53. • Tier 3: 6–8 residents in a Group Home: $328.36. • Tier 3: 9–10 residents in a Group Home: $262.69. • Room and Board (non-Medicaid funds): up to 5 residents: $39.00. • Room and Board (non-Medicaid funds): 6–10 residents: $33.00.
T2033 HK: • Residential care, NOS, waiver, per diem, Tier 4. • HK = Specialized mental health program for high-risk populations.	Respite in Group Home Tier 4, per diem: • Tier 4: up to 5 residents in a Group Home: $399.28. • Tier 4: 6–8 residents in a Group Home: $328.36. • Tier 4: 9–10 residents in a Group Home: $262.69. • Room and Board (non-Medicaid funds): $39.00. • Room and Board (non-Medicaid funds): 6–10 residents: $33.00.

Short Term Small Group Supported Employment

Service Specification	
Service Title:	Short Term Small Group Supported Employment (STSGSE)
Service Definition (Scope):	

STSGSE services provide support to beneficiaries to gain skills to enable transition to integrated, competitive employment. This service is provided instead of IESS only when the beneficiary specifically chooses this service over IESS, based on a desire to work in a group context or to earn income more quickly than might be possible with an individualized, rapid job search through IESS. STSGSE is services and training activities provided in regular business, industry, and community settings for groups of two (2) to four (4) workers with disabilities. Examples include mobile crews and other employment work groups. STSGSE must be provided in a manner that promotes integration into the workplace and interaction between beneficiaries and people without disabilities in those workplaces. The outcome of this service is sustained paid employment and work experience leading to further career development, and beneficiary integrated community-based employment. Within this service, the beneficiary is compensated at or above 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 beneficiaries without disabilities.

STSGSE may be a combination of the following services: on-the-job supports, initial and ongoing employment planning and advancement, employment assessment not otherwise covered in the annual career planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefits support training, and planning transportation. If the beneficiary has received a career assessment that has determined that the beneficiary is in need of acquiring particular skills in order to enhance their employability, those identified skill development areas must be addressed within the beneficiary's Recovery Plan and by the STSGSE. Beneficiaries receiving this service must have an employment outcome goal included in their Recovery Plan.

On-the-job support includes on site job training, assisting the beneficiary to develop natural supports in the workplace, coordinating with employers and coworkers, as necessary, to assist the beneficiary in meeting employment expectations, and addressing issues as they arise. Other workplace support services may include services not specifically related to job skill training that enable the waiver beneficiary to be successful in integrating into the job setting.

STSGSE includes person-centered, comprehensive employment planning and support service that provides assistance for waiver program beneficiaries to obtain, maintain, or advance in competitive employment or self-employment. This employment planning includes engaging a beneficiary 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 activity is documentation of the beneficiary's stated career objective and a career plan used to guide beneficiary employment support.

STSGSE emphasizes the importance of rapid job search for a competitive job and provide work experiences where the beneficiary can develop strengths and skills that contribute to employability in individualized paid employment in integrated community settings. STSGSE includes the provision of scheduled activities outside of a beneficiary's home that support acquisition, retention, or improvement in self-care, sensory-motor development, socialization, daily living skills, communication, community living, and social skills. STSGSE includes supervision, monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills and training and education in self-determination. Skills development, as a part of placement and training, may occur as a one-on-one training experience in accordance with DHSS requirements. STSGSE will be utilized for a beneficiary to gain work related experience considered crucial for job placement (e.g., unpaid internship). STSGSE provides and supports the acquisition of skills necessary to enable the beneficiary to obtain competitive, integrated work where the compensation for the beneficiary is 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 beneficiaries without disabilities, which is considered to be the optimal outcome of STSGSE.

Services must be delivered in a manner that supports the beneficiary's communication needs including, but not limited to, age-appropriate communication, translation/Interpretation services for beneficiaries that are of limited-English proficiency, or who have other communication needs requiring translation, and assistance with the provider's understanding and use of communication devices used by the beneficiary.

This service may be delivered in Delaware and in states contiguous to Delaware.

The STSGSE service provider must maintain documentation in accordance with DHSS requirements. The documentation must be available to the Care Manager for monitoring at all times on an ongoing basis. The Care Manager will monitor on a quarterly basis to see if the objectives and outcomes are being met. Competitive and integrated employment, including self-employment, shall be considered the first option when serving persons with disabilities who are of working age.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

STSGSE may not be rendered to a beneficiary eligible for such services under a program funded by either the Rehabilitation Act of 1973 as amended, or the IDEA, or any other small business development resource available to the beneficiary. Documentation in accordance with DHSS requirements must be maintained in the file by the Care Manager and updated with each reauthorization to satisfy the State assurance that the service is not otherwise available to the beneficiary under other federal programs.

Prior authorization for STSGSE is required. Documentation must be provided that STSGSE is the beneficiary's preference among employment options and/or that it enabled the beneficiary to achieve a stated goal of quickly obtaining income from employment. Continuation of STSGSE requires a review and reauthorization every six (6) months in accordance with DHSS requirements, and shall not exceed 12 continuous months without obtaining information from an employment assessment and/or exploration of alternative services. The review and reauthorization should verify that there have been appropriate attempts to prepare the beneficiary for a transition to IESS and that the beneficiary continues to prefer STSGSE, despite these attempts.

Except as permitted in accordance with requirements contained in DHSS 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.

This service must occur in integrated settings and may not occur in non-integrated settings.

STSGSE services do not include volunteer work and may not be for job placements paying below minimum wage.

Federal Financial Participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in STSGSE services.
- Payments that are passed through to users of STSGSE beneficiaries.

STSGSE services do not include payment for supervision, training, support, and adaptations typically available to other workers filling similar positions in the business.

STSGSE 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.

STSGSE is not a pre-requisite for individualized, integrated Supported Employment under Supported Employment — Individual.

The Care Manager must ensure that the provider maintains documentation and that the Care Manager monitors the services on an ongoing basis to ensure that the health and welfare of the beneficiary is met, and the Recovery Plan goals are achieved. The documentation must be available to the Care Manager for monitoring at all times, on an ongoing basis. Documentation in accordance with DHSS requirements must be maintained in the beneficiary's file by the Care Manager and updated with each reauthorization, as applicable.

Provider Specifications				
Provider Category(s) (check one or both):	☐	Individual (list types):	X	Agency (list types):
				STSGSE Agency.

Specify whether the service may be provided by (check each that applies):	☐	Legally Responsible Person.	☐	Relative/Legal Guardian.

Provider Qualifications			
Provider Type:	**License (specify):**	**Certificate (specify):**	**Other Standard (specify):**
STSGSE Agency.	State Business License or 501(c)(3) status.	• PROMISE Certified Provider (utilizing DDDS Waiver Criteria). • Division of Vocational Rehabilitation Vendor for Job Development, Placement, and Retention Services.	• Comply with DHSS standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. • Meet minimum standards as set forth by Division of Vocational Rehabilitation or Division for the Visually Impaired, as applicable for comparable services. • Ensure employees and/or contractors complete DHSS-required training, including training on the beneficiary's Recovery Plan and the beneficiary's unique and/or disability-specific needs, which may include, but are not limited to, communication, mobility, and behavioral needs. • Individuals employed by a STSGSE Agency must: – Have criminal background investigations in accordance with State requirements. – Have a screening against the child abuse and adult abuse registry checks, 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 finding 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 DHSS.

Verification of Provider Qualifications:		
Provider Type:	***Entity Responsible for Verification:***	***Frequency of Verification:***
Supported Employment Agency.	DHSS or Designee.	Initially and annually (or more frequently, based on service monitoring concerns).

Service Delivery Method				
Service Delivery Method (check each that applies):	☐	Participant-directed.	X	Provider managed.

Billing Method	
Bill Code:	**Billing Rate and Unit:**
T2019 UN: • Habilitation, Supported Employment, waiver, per 15 minutes. • UN = 2 patients served. T2019 UP: • Habilitation, Supported Employment, waiver, per 15 minutes. • UP = 3 patients served. T2019 UQ: • Habilitation, Supported Employment, waiver, per 15 minutes. • UQ = 4 patients served.	Separate rates for different small group sizes: • (1:2): $6.81 per 15 minutes. • (1:3): $4.71 per 15 minutes. • (1:4): $3.67 per 15 minutes.

Appendices: Certification Detail for Evidence-Based Practices under PROMISE

Appendix 1: Delaware State Standards

Please refer to DSAMH's website for the most updated version of the Delaware State Standards:

ACT Standards
https://www.dhss.delaware.gov/dhss/dsamh/files/ACTStandards.pdf

ICM Standards
https://www.dhss.delaware.gov/dhss/dsamh/files/icmstandards.pdf

Appendix 2: Certification Detail for Supported Employment Evidence-Based Practice (EBP) Certification

Admission Criteria

Individuals who are eligible for Supported Employment, are beneficiaries eligible for PROMISE, and who have indicated that employment-related goals are important to their recovery from mental illness.

Beneficiaries in the PROMISE program are not required to achieve an additional level of symptom relief or functioning improvement in order to be eligible for Supported Employment services. The only eligibility criteria are those defined above.

Supported Employment Service Definitions

Within the PROMISE program, Supported Employment services are provided through two distinct services:

1. Individual Employment Support Services (IESS).
2. Short Term Small Group Supported Employment (STSGSE).

Both have multiple types of service activities that constitute the service. **See the referenced service definitions for Supported Employment activities that are eligible for reimbursement.**

Recommended Authorizations for IESS

- Intensive IESS (IIESS). Authorization is for one (1) year, with a recommended six (6)-month review by the PROMISE Care Manager. After two (2) years of service, the provider must supply a rationale as to why the person cannot receive Extended Follow Along (EFA) (see below), and the PROMISE Care Manager must concur.
- EFA. Authorization is for one (1) year, with a recommended six (6)-month review by the PROMISE Care Manager.

Fidelity to the Supported Employment Model

The Individual Placement and Support (IPS) model of Supported Employment is the vocational program for people with serious mental illnesses (SMIs) that has the best evidence base. A set of scales for measuring and rating programs in relationship to the evidence-based model has been developed and these scales are provided below. Programs should, at a minimum, adhere to the following critical ingredients of the IPS model:

- Conduct rapid job searches with beneficiaries (as “readiness” programs are not found to be helpful).
- Help beneficiaries obtain competitive, integrated jobs (versus “set-aside” employment for people with disabilities).
- Provide job coaching and intensive ongoing support to people at every stage of job placement.
- Individualize services, based on the beneficiary’s vocational goals and preferences, as well as on his or her relative strengths and limitations in finding, obtaining, and maintaining employment.
- Actively develop jobs by establishing collaborative relationships with a wide variety of potential employers.

- Ensure integration of Supported Employment services with clinical services, through the Employment Specialist's active participation and collaboration with each beneficiary's clinical team.

The fidelity scales following this section constitute an important approach to assessing Supported Employment programs and services.

STSGSE

There is no specific fidelity tool available for this service. However, the PROMISE Home and Community-based Services Service Manual (Service Manual) describes core elements of this model, and the State should use its Quality Assurance function to assess the extent to which programs are following the core elements that are outlined in the Service Manual.

Supported Employment Staffing and Qualifications

Staffing and Qualifications for IESS

The IPS model dictates that a small group of between two (2) and 10 Employment Specialists work with caseloads of 20 beneficiaries each. Caseloads will include a mix of beneficiaries who have been authorized for IIESS and EFA.

Employment Specialists are supervised by a Team Leader, who also serves as an Employment Specialist, but for a smaller number of beneficiaries (approximately eight (8) at any one time).

Employment Specialists serving on Assertive Community Treatment (ACT) teams also should follow the core fidelity elements of the IPS model.

For the PROMISE program, we recommend the following typical staffing for IPS Supported Employment teams, allowing for variation within the bounds of currently recognized fidelity (two (2) to 10 Employment Specialists):

Staff	FTE	Caseload	Total Served
Team Lead	1	8	8
Employment Specialists	5	20	100
Total	**6**	**N/A**	**108**

Employment Specialist Qualifications

Experts agree that the amount of past vocational training is less important than being willing to embrace the IPS model. Employment Specialists with much past training in opposing models can sometimes actually be less effective than those with less general vocational training who receive IPS training for their work as Employment Specialists.

An Employment Specialist should have a bachelor's degree, meet the regulatory requirements for Associate Clinicians, and once employed, should complete the requisite training in the IPS model of Supported Employment described below. They should also have had a minimum of one (1) year experience living or working with an individual with a disability or related support needs, similar to those of the beneficiaries served in the waiver (or related educational experience).

However, note that the Tool for the Measurement of Assertive Community Treatment (TMACT), the latest and best approach to assessing the fidelity of ACT teams, does recommend that Employment Specialists either have a degree in the vocational rehabilitation field or one (1) year of full-time

experience providing employment services to people with SMIs. The more stringent requirements from TMACT are important in the ACT team context because Employment Specialists on ACT teams must often function independently (i.e., without the benefit of having an IPS/Supported Employment-specific Team Leader).

Team Leader Qualifications
Supported Employment Team Leaders should either be Associate Clinicians who have bachelor's degrees and at least five (5) years of experience working as an Employment Specialist, or they should be Qualified State Plan Providers who hold at least a master's degree and who have at least one (1) year experience working as an Employment Specialist.

Required Training for PROMISE Providers

All providers of both IESS and STSGSE should receive training in the IPS model of Supported Employment from a recognized expert in the model.[1] For providers who have not yet received training in the model, training should include a two (2)-day event during which trainees are presented with each key aspect of the IPS model (thereby covering all fidelity items). All providers of this EBP should receive at least one day of continuing education/training in the IPS model each year thereafter. Clinical/Program Leads from provider agencies also should participate in the training, if they have not already received IPS training.

In addition to participating in the two (2)-day IPS model training, Team Leaders should receive a one (1)-day training on the role of the Team Leader in the IPS model. In subsequent years, they should also receive at least one (1) day of continuing education/training in the model, along with Employment Specialists.

Next Steps — Including Development of an EBP Certification Model

For program certification:

- Identify required fidelity levels for the IPS model, overall, as well as for what are considered critical fidelity elements of IPS.
- Specify the reimbursement implications of meeting or not meeting those requirements.

[1]STSGSE providers should also receive training due to the fact that the PROMISE Program is going to rely on them to appropriately prepare people for and transfer them to the more recovery-oriented IESS services. STSGESE providers need to appropriate as many of the core elements of the IPS model as they can in the STSGSE context.

SUPPORTED EMPLOYMENT FIDELITY SCALE*
1/7/08

SUPPORTED EMPLOYMENT FIDELITY SCALE*
1/7/08

Rater: **Site:** **Date:** **Total Score:**

Directions: Circle one anchor number for each criterion.

Criterion	Data Source**	Anchor
Staffing		
1. Caseload size: Employment specialists have individual employment caseloads. The maximum caseload for any full-time employment specialist is 20 or fewer clients.	MIS, DOC, INT	1= Ratio of 41 or more clients per employment specialist. 2= Ratio of 31-40 clients per employment specialist. 3= Ratio of 26-30 clients per employment specialist. 4= Ratio of 21-25 clients per employment specialist. 5= Ratio of 20 or fewer clients per employment specialist.
2. Employment services staff: Employment specialists provide only employment services.	MIS, DOC INT	1= Employment specialists provide employment services less than 60% of the time. 2= Employment specialists provide employment services 60 - 74% of the time. 3= Employment specialists provide employment services 75 - 89% of the time. 4= Employment specialists provide employment services 90 - 95% of the time. 5= Employment specialists provide employment services 96% or more of the time.

*Formerly called IPS Model Fidelity Scale
**See end of document for key

3. Vocational generalists: Each employment specialist carries out all phases of employment service, including intake, engagement, assessment, job placement, job coaching, and follow-along supports before step down to less intensive employment support from another MH practitioner. (Note: It is not expected that each employment specialist will provide benefits counseling to their clients. Referrals to a highly trained benefits counselor are in keeping with high fidelity, see Item # 1 in "Services".)	MIS, DOC, INT, OBS	1= Employment specialist only provides vocational referral service to vendors and other programs. 2= Employment specialist maintains caseload but refers clients to other programs for vocational services. 3= Employment specialist provides one to four phases of the employment service (e.g. intake, engagement, assessment, job development, job placement, job coaching, and follow along supports). 4= Employment specialist provides five phases of employment service but not the entire service. 5= Employment specialist carries out all six phases of employment service (e.g. program intake, engagement, assessment, job development/job placement, job coaching, and follow-along supports).

ORGANIZATION

1. Integration of rehabilitation with mental health treatment thru team assignment: Employment specialists are part of up to 2 mental health treatment teams from which at least 90% of the employment specialist's caseload is comprised.	MIS, DOC, INT, OBS	1= Employment specialists are part of a vocational program that functions separately from the mental health treatment. 2= Employment specialists are attached to three or more mental health treatment teams. OR Clients are served by individual mental health practitioners who are not organized into teams. OR Employment specialists are attached to one or two teams from which less than 50% of the employment specialist's caseload is comprised. 3= Employment specialists are attached to one or two mental health treatment teams, from which at least 50 - 74% of the employment specialist's caseload is comprised. 4= Employment specialists are attached to one or two mental health treatment teams, from which at least 75 - 89% of the employment specialist's caseload is comprised. 5= Employment specialists are attached to one or two mental health treatment teams, from which 90 - 100% of the employment specialist's caseload is comprised.

2. Integration of rehabilitation with mental health treatment thru frequent team member contact: Employment specialists actively participate in weekly mental health treatment team meetings (not replaced by administrative meetings) that discuss individual clients and their employment goals with shared decision-making. Employment specialist's office is in close proximity to (or shared with) their mental health treatment team members. Documentation of mental health treatment and employment services is integrated in a single client chart. Employment specialists help the team think about employment for people who haven't yet been referred to supported employment services.	MIS, DOC INT, OBS	1= One or none is present. 2= Two are present 3= Three are present. 4= Four are present. 5= Five are present. All five key components are present. • Employment specialist attends weekly mental health treatment team meetings. • Employment specialist participates actively in treatment team meetings with shared decision-making. • Employment services documentation (i.e., vocational assessment/profile, employment plan, progress notes) is integrated into client's mental health treatment record. • Employment specialist's office is in close proximity to (or shared with) their mental health treatment team members. • Employment specialist helps the team think about employment for people who haven't yet been referred to supported employment services.
3. Collaboration between employment specialists and Vocational Rehabilitation counselors: The employment specialists and VR counselors have frequent contact for the purpose of discussing shared clients and identifying potential referrals.	DOC, INT OBS, ISP	1= Employment specialists and VR counselors have client-related contacts (phone, e-mail, in person) less than quarterly to discuss shared clients and referrals. OR Employment specialists and VR counselors do not communicate. 2= Employment specialists and VR counselors have client-related contacts (phone, e-mail, in person) at least quarterly to discuss shared clients and referrals. 3= Employment specialists and VR counselors have client-related contacts (phone, e-mail, in-person) monthly to discuss shared clients and referrals. 4= Employment specialists and VR counselors have scheduled, face-to-face

		meetings at least quarterly, OR have client-related contacts (phone, e-mail, in person) weekly to discuss shared clients and referrals. 5= Employment specialists and VR counselors have scheduled, face-to-face meetings at least monthly and have client-related contacts (phone, e-mail, in person) weekly to discuss shared clients and referrals.
4. Vocational unit: At least 2 full-time employment specialists and a team leader comprise the employment unit. They have weekly client-based group supervision following the supported employment model in which strategies are identified and job leads are shared. They provide coverage for each other's caseload when needed.	MIS, INT, OBS	1= Employment specialists are not part of a vocational unit. 2= Employment specialists have the same supervisor but do not meet as a group. They do not provide back-up services for each other's caseload. 3= Employment specialists have the same supervisor and discuss clients between each other on a weekly basis. They provide back-up services for each other's caseloads as needed. OR, If a program is in a rural area where employment specialists are geographically separate with one employment specialist at each site, the employment specialists meet 2-3 times monthly with their supervisor by teleconference. 4= At least 2 employment specialists and a team leader form an employment unit with 2-3 regularly scheduled meetings per month for client-based group supervision in which strategies are identified and job leads are shared and discuss clients between each other. They provide coverage for each other's caseloads when needed. OR, If a program is in a rural area where employment specialists are geographically separate with one employment specialist at each site, the employment specialists meet 2-3 times per month with their supervisor in person or by teleconference and mental health practitioners are available to help the employment specialist with activities such as taking someone to work or picking up job applications. 5= At least 2 full-time employment specialists and a team leader form an employment unit with weekly client-based group supervision based on the supported employment model in which strategies are identified and job leads are shared. They provide coverage for each other's caseloads when needed.

5. Role of employment supervisor: Supported employment unit is led by a supported employment team leader. Employment specialists' skills are developed and improved through outcome-based supervision. All five key roles of the employment supervisor are present.	MIS, INT, DOC, OBS	1= One or none is present. 2= Two are present. 3= Three are present. 4= Four are present. 5= Five are present. Five key roles of the employment supervisor: • One full-time equivalent (FTE) supervisor is responsible for no more than 10 employment specialists. The supervisor does not have other supervisory responsibilities. (Program leaders supervising fewer than ten employment specialists may spend a percentage of time on other supervisory activities on a prorated basis. For example, an employment supervisor responsible for 4 employment specialists may be devoted to SE supervision half time.) • Supervisor conducts weekly supported employment supervision designed to review client situations and identify new strategies and ideas to help clients in their work lives. • Supervisor communicates with mental health treatment team leaders to ensure that services are integrated, to problem solve programmatic issues (such as referral process, or transfer of follow-along to mental health workers) and to be a champion for the value of work. Attends a meeting for each mental health treatment team on a quarterly basis. • Supervisor accompanies employment specialists, who are new or having difficulty with job development, in the field monthly to improve skills by observing, modeling, and giving feedback on skills, e.g., meeting employers for job development. • Supervisor reviews current client outcomes with employment specialists and sets goals to improve program performance at least quarterly.

5. Role of employment supervisor: Supported employment unit is led by a supported employment team leader. Employment specialists' skills are developed and improved through outcome-based supervision. All five key roles of the employment supervisor are present.	MIS, INT, DOC, OBS	1= One or none is present. 2= Two are present. 3= Three are present. 4= Four are present. 5= Five are present. Five key roles of the employment supervisor: • One full-time equivalent (FTE) supervisor is responsible for no more than 10 employment specialists. The supervisor does not have other supervisory responsibilities. (Program leaders supervising fewer than ten employment specialists may spend a percentage of time on other supervisory activities on a prorated basis. For example, an employment supervisor responsible for 4 employment specialists may be devoted to SE supervision half time.) • Supervisor conducts weekly supported employment supervision designed to review client situations and identify new strategies and ideas to help clients in their work lives. • Supervisor communicates with mental health treatment team leaders to ensure that services are integrated, to problem solve programmatic issues (such as referral process, or transfer of follow-along to mental health workers) and to be a champion for the value of work. Attends a meeting for each mental health treatment team on a quarterly basis. • Supervisor accompanies employment specialists, who are new or having difficulty with job development, in the field monthly to improve skills by observing, modeling, and giving feedback on skills, e.g., meeting employers for job development. • Supervisor reviews current client outcomes with employment specialists and sets goals to improve program performance at least quarterly.

6. Zero exclusion criteria: All clients interested in working have access to supported employment services regardless of job readiness factors, substance abuse, symptoms, history of violent behavior, cognition impairments, treatment non-adherence, and personal presentation. These apply during supported employment services too. Employment specialists offer to help with another job when one has ended, regardless of the reason that the job ended or number of jobs held. If VR has screening criteria, the mental health agency does not use them to exclude anybody. Clients are not screened out formally or informally.	DOC, INT OBS	1= There is a formal policy to exclude clients due to lack of job readiness (e.g., substance abuse, history of violence, low level of functioning, etc.) by employment staff, case managers, or other practitioners. 2= Most clients are unable to access supported employment services due to perceived lack of job readiness (e.g., substance abuse, history of violence, low level of functioning, etc.). 3= Some clients are unable to access supported employment services due to perceived lack of job readiness (e.g., substance abuse, history of violence, low level of functioning, etc.). 4= No evidence of exclusion, formal or informal. Referrals are not solicited by a wide variety of sources. Employment specialists offer to help with another job when one has ended, regardless of the reason that the job ended or number of jobs held. 5= All clients interested in working have access to supported employment services. Mental health practitioners encourage clients to consider employment, and referrals for supported employment are solicited by many sources. Employment specialists offer to help with another job when one has ended, regardless of the reason that the job ended or number of jobs held.
7. Agency focus on competitive employment: Agency promotes competitive work through multiple strategies. Agency intake includes questions about interest in employment. Agency displays written postings (e.g., brochures, bulletin boards, posters) about employment and supported employment services. The focus should be with the agency programs that provide services to adults with severe mental illness. Agency supports ways for clients to share work stories with other clients and staff. Agency measures rate of competitive employment and shares this information with agency leadership and staff.	DOC, INT, OBS	1= One or none is present. 2= Two are present. 3= Three are present. 4= Four are present. 5= Five are present. Agency promotes competitive work through multiple strategies: • Agency intake includes questions about interest in employment. • Agency includes questions about interest in employment on all annual (or semi-annual) assessment or treatment plan reviews.

		• Agency displays written postings (e.g., brochures, bulletin boards, posters) about working and supported employment services, in lobby and other waiting areas. • Agency supports ways for clients to share work stories with other clients and staff (e.g., agency-wide employment recognition events, in-service training, peer support groups, agency newsletter articles, invited speakers at client treatment groups, etc.) at least twice a year. • Agency measures rate of competitive employment on at least a quarterly basis and shares outcomes with agency leadership and staff.
8. Executive team support for SE: Agency executive team members (e.g., CEO/Executive Director, Chief Operating Officer, QA Director, Chief Financial Officer, Clinical Director, Medical Director, Human Resource Director) assist with supported employment implementation and sustainability. All five key components of executive team support are present.	DOC, INT, OBS	1= One is present. 2= Two are present. 3= Three are present. 4= Four are present. 5= Five are present. • Executive Director and Clinical Director demonstrate knowledge regarding the principles of evidence-based supported employment. • Agency QA process includes an explicit review of the SE program, or components of the program, at least every 6 months through the use of the Supported Employment Fidelity Scale or until achieving high fidelity, and at least yearly thereafter. Agency QA process uses the results of the fidelity assessment to improve SE implementation and sustainability. • At least one member of the executive team actively participates at SE leadership team meetings (steering committee meetings) that occur at least every six months for high fidelity programs and at least quarterly for programs that have not yet achieved high fidelity. Steering committee is defined as a diverse group of stakeholders charged with reviewing fidelity, program implementation, and the service delivery system. Committee develops written action plans aimed at developing or sustaining high fidelity services.

		• The agency CEO/Executive Director communicates how SE services support the mission of the agency and articulates clear and specific goals for SE and/or competitive employment to all agency staff during the first six months and at least annually (i.e., SE kickoff, all-agency meetings, agency newsletters, etc.). This item is not delegated to another administrator. • SE program leader shares information about EBP barriers and facilitators with the executive team (including the CEO) at least twice each year. The executive team helps the program leader identify and implement solutions to barriers.
SERVICES		
1. Work incentives planning: All clients are offered assistance in obtaining comprehensive, individualized work incentives planning before starting a new job and assistance accessing work incentives planning thereafter when making decisions about changes in work hours and pay. Work incentives planning includes SSA benefits, medical benefits, medication subsidies, housing subsidies, food stamps, spouse and dependent children benefits, past job retirement benefits and any other source of income. Clients are provided information and assistance about reporting earnings to SSA, housing programs, VA programs, etc., depending on the person's benefits.	DOC, INT OBS, ISP	1= Work incentives planning is not readily available or easily accessible to most clients served by the agency. 2= Employment specialist gives client contact information about where to access information about work incentives planning. 3= Employment specialist discusses with each client changes in benefits based on work status. 4= Employment specialist or other MH practitioner offer clients assistance in obtaining comprehensive, individualized work incentives planning by a person trained in work incentives planning prior to client starting a job. 5= Employment specialist or other MH practitioner offer clients assistance in obtaining comprehensive, individualized work incentives planning by a specially trained work incentives planner prior to starting a job. They also facilitate access to work incentives planning when clients need to make decisions about changes in work hours and pay. Clients are provided information and assistance about reporting earnings to SSA, housing programs, etc., depending on the person's benefits.
2. Disclosure: Employment specialists provide clients with accurate information and assist with evaluating their choices to make an informed decision regarding what is revealed to the employer about having a disability.	DOC, INT OBS	1= None is present. 2= One is present. 3= Two are present. 4= Three are present. 5= Four are present. • Employment specialists do not require all clients to disclose their psychiatric disability at the work site in order to receive services. • Employment specialists offer to discuss with clients the possible costs and benefits (pros and cons) of disclosure at the work site in advance of clients disclosing at the work site. Employment specialists describe how disclosure relates to requesting accommodations and the employment specialist's role communicating with the employer. • Employment specialists discuss specific information to be disclosed (e.g., disclose receiving mental health treatment, or presence of a psychiatric disability, or difficulty with anxiety, or unemployed for a period of time, etc.) and offers examples of what could be said to employers. • Employment specialists discuss disclosure on more than one occasion (e.g., if clients have not found employment after two months or if clients report difficulties on the job.)
3. Ongoing, work-based vocational assessment: Initial vocational assessment occurs over 2-3 sessions and is updated with information from work experiences in competitive jobs. A vocational profile form that includes information about preferences, experiences, skills, current adjustment, strengths, personal contacts, etc, is updated with each new job experience. Aims at problem solving using environmental assessments and consideration of reasonable accommodations. Sources of information include the client, treatment team, clinical records, and with	DOC, INT, OBS, ISP	1= Vocational evaluation is conducted prior to job placement with emphasis on office-based assessments, standardized tests, intelligence tests, work samples. 2= Vocational assessment may occur through a stepwise approach that includes: prevocational work experiences (e.g., work units in a day program), volunteer jobs, or set aside jobs (e.g., NISH jobs agency-run businesses, sheltered workshop jobs, affirmative businesses, enclaves). 3= Employment specialists assist clients in finding competitive jobs directly without systematically reviewing interests, experiences, strengths,

the client's permission, from family members and previous employers.		etc. and do not routinely analyze job loss (or job problems) for lessons learned. 4= Initial vocational assessment occurs over 2-3 sessions in which interests and strengths are explored. Employment specialists help clients learn from each job experience and also work with the treatment team to analyze job loss, job problems and job successes. They do not document these lessons learned in the vocational profile, OR The vocational profile is not updated on a regular basis. 5= Initial vocational assessment occurs over 2-3 sessions and information is documented on a vocational profile form that includes preferences, experiences, skills, current adjustment, strengths, personal contacts, etc. The vocational profile form is used to identify job types and work environments. It is updated with each new job experience. Aims at problem solving using environmental assessments and consideration of reasonable accommodations. Sources of information include the client, treatment team, clinical records, and with the client's permission, from family members and previous employers. Employment specialists help clients learn from each job experience and also work with the treatment team to analyze job loss, job problems and job successes.
4. Rapid job search for competitive job: Initial employment assessment and first face-to-face employer contact by the client or the employment specialist about a competitive job occurs within 30 days (one month) after program entry.	DOC, INT, OBS, ISP	1= First face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average 271 days or more (> 9 mos.) after program entry. 2= First face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average between 151 and 270 days (5-9 mos.) after program entry. 3= First face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average between 61 and 150 days (2-5 mos.) after program entry. 4= First face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average between 31 and 60 days (1-2 mos.) after program entry. 5= The program tracks employer contacts and the first face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average within 30 days (one month) after program entry.

5. Individualized job search: Employment specialists make employer contacts aimed at making a good job match based on clients' preferences (relating to what each person enjoys and their personal goals) and needs (including experience, ability, symptomatology, health, etc.) rather than the job market (i.e., those jobs that are readily available). An individualized job search plan is developed and updated with information from the vocational assessment/profile form and new job/educational experiences.	DOC, INT OBS, ISP	1= Less than 25% of employer contacts by the employment specialist are based on job choices which reflect client's preferences, strengths, symptoms, etc. rather than the job market. 2= 25-49% of employer contacts by the employment specialist are based on job choices which reflect client's preferences, strengths, symptoms, etc., rather than the job market. 3= 50-74% of employer contacts by the employment specialist are based on job choices which reflect client's preferences, strengths, symptoms, etc., rather than the job market. 4= 75-89% of employer contacts by the employment specialist are based on job choices which reflect client's preferences, strengths, symptoms, etc., rather than the job market and are consistent with the current employment plan. 5= Employment specialist makes employer contacts based on job choices which reflect client's preferences, strengths, symptoms, lessons learned from previous jobs etc., 90-100% of the time rather than the job market and are consistent with the current employment/job search plan. When clients have limited work experience, employment specialists provide information about a range of job options in the community.
6. Job development - Frequent employer contact: Each employment specialist makes at least 6 face to-face employer contacts per week on behalf of clients looking for work. (Rate for each then calculate average and use the closest scale point.) An employer contact is counted even when an employment specialist meets the same employer more than one time in a week, and when the client is present or not present. Client-specific and generic contacts are included. Employment specialists use a weekly tracking form to document employer contacts.	DOC, INT	1= Employment specialist makes less than 2 face-to-face employer contacts that are client-specific per week. 2= Employment specialist makes 2 face-to-face employer contacts per week that are client-specific, OR Does not have a process for tracking. 3= Employment specialist makes 4 face-to-face employer contacts per week that are client-specific, and uses a tracking form that is reviewed by the SE supervisor on a monthly basis. 4= Employment specialist makes 5 face-to-face employer contacts per week that are client-specific, and uses a tracking form that is reviewed by the SE supervisor on a weekly basis.

		5= Employment specialist makes 6 or more face-to-face employer contacts per week that are client specific, or 2 employer contacts times the number of people looking for work when there are less than 3 people looking for work on their caseload (e.g., new program). In addition, employment specialist uses a tracking form that is reviewed by the SE supervisor on a weekly basis.
7. Job development - Quality of employer contact: Employment specialists build relationships with employers through multiple visits in person that are planned to learn the needs of the employer, convey what the SE program offers to the employer, describe client strengths that are a good match for the employer. (Rate for each employment specialist, then calculate average and use the closest scale point.)	DOC, INT, OBS	1= Employment specialist meets employer when helping client to turn in job applications, OR Employment specialist rarely makes employer contacts. 2= Employment specialist contacts employers to ask about job openings and then shares these "leads" with clients. 3= Employment specialist follows up on advertised job openings by introducing self, describing program, and asking employer to interview client. 4= Employment specialist meets with employers in person whether or not there is a job opening, advocates for clients by describing strengths and asks employers to interview clients. 5= Employment specialist builds relationships with employers through multiple visits in person that are planned to learn the needs of the employer, convey what the SE program offers to the employer, describe client strengths that are a good match for the employer.
8. Diversity of job types: Employment specialists assist clients in obtaining different types of jobs.	DOC, INT, OBS, ISP	1= Employment specialists assist clients obtain different types of jobs less than 50% of the time. 2= Employment specialists assist clients obtain different types of jobs 50-59% of the time. 3= Employment specialists assist clients obtain different types of jobs 60-69% of the time. 4= Employment specialists assist clients obtain different types of jobs70-84% of the time.

		5= Employment specialists assist clients obtain different types of jobs 85-100% of the time.
9. Diversity of employers: Employment specialists assist clients in obtaining jobs with different employers.	DOC, INT, OBS, ISP	1= Employment specialists assist clients obtain jobs with the different employers less than 50% of the time. 2= Employment specialists assist clients obtain jobs with the same employers 50-59% of the time. 3= Employment specialists assist clients obtain jobs with different employers 60-69% of the time. 4= Employment specialists assist clients obtain jobs with different employers 70-84% of the time. 5= Employment specialists assist clients obtain jobs with different employers 85-100% of the time.
10. Competitive jobs: Employment specialists provide competitive job options that have permanent status rather than temporary or time-limited status, e.g., TE (transitional employment positions). Competitive jobs pay at least minimum wage, are jobs that anyone can apply for and are not set aside for people with disabilities. (Seasonal jobs and jobs from temporary agencies that other community members use are counted as competitive jobs.)	DOC, INT, OBS, ISP	1= Employment specialists provide options for permanent, competitive jobs less than 64% of the time, OR There are fewer than 10 current jobs. 2= Employment specialists provide options for permanent, competitive jobs about 65- 74% of the time. 3= Employment specialists provide options for permanent competitive jobs about 75-84%% of the time. 4= Employment specialists provide options for permanent competitive jobs about 85-94% of the time. 5= 95% or more competitive jobs held by clients are permanent.
11. Individualized follow-along supports: Clients receive different types of support for working a job that are based on the job, client preferences, work history, needs, etc. Supports are provided by a variety of people, including treatment team members (e.g., medication changes, social skills training, encouragement), family, friends, co-workers (i.e., natural supports), and employment specialist. Employment specialist also provides employer support (e.g., educational information, job accommodations) at client's request. Employment specialist offers help with career development, i.e., assistance with education, a more desirable job, or more preferred job duties.	DOC, INT, OBS, ISP	1= Most clients do not receive supports after starting a job. 2= About half of the working clients receive a narrow range of supports provided primarily by the employment specialist. 3= Most working clients receive a narrow range of supports that are provided primarily by the employment specialist. 4= Clients receive different types of support for working a job that are based on the job, client preferences, work history, needs, etc. Employment specialists provide employer supports at the client's request. 5= Clients receive different types of support for working a job that are based on the job, client preferences, work history, needs, etc. Employment specialist also provides employer support (e.g., educational information, job accommodations) at client's request. The employment specialist helps people move onto more preferable jobs and also helps people with school or certified training programs. The site provides examples of different types of support including enhanced supports by treatment team members.
12. Time-unlimited follow-along supports: Employment specialists have face-to-face contact within 1 week before starting a job, within 3 days after starting a job, weekly for the first month, and at least monthly for a year or more, on average, after working steadily, and desired by clients. Clients are transitioned to step down job supports from a mental health worker following steady employment. Employment specialists contact clients within 3 days of learning about the job loss.	DOC, INT, OBS, ISP	1= Employment specialist does not meet face-to-face with the client after the first month of starting a job. 2= Employment specialist has face-to-face contact with less than half of the working clients for at least 4 months after starting a job. 3= Employment specialist has face-to-face contact with at least half of the working clients for at least 4 months after starting a job. 4= Employment specialist has face-to-face contact with working clients weekly for the first month after starting a job, and at least monthly for a year or more, on average, after working steadily, and desired by clients. 5= Employment specialist has face-to-face contact within 1 week before starting a job, within 3 days after starting a job, weekly for the first month, and at least monthly for a year or more, on average, after working steadily and desired by clients. Clients are transitioned to step down job supports, from a mental health worker following steady employment clients. Clients are transitioned to step down job supports from a mental health worker following steady employment.

		Employment specialist contacts clients within 3 days of hearing about the job loss.
13. Community-based services: Employment services such as engagement, job finding and follow-along supports are provided in natural community settings by all employment specialists. (Rate each employment specialist based upon their total weekly scheduled work hours, then calculate the average and use the closest scale point.)	DOC, INT OBS	1= Employment specialist spends 30% time or less in the scheduled work hours in the community. 2= Employment specialist spends 30 - 39% time of total scheduled work hours in the community. 3= Employment specialist spends 40 -49% of total scheduled work hours in the the community. 4= Employment specialist spends 50 - 64% of total scheduled work hours in the community. 5= Employment specialist spends 65% or more of total scheduled work hours in the community.
14. Assertive engagement and outreach by integrated treatment team: Service termination is not based on missed appointments or fixed time limits. Systematic documentation of outreach attempts. Engagement and outreach attempts made by integrated team members. Multiple home/community visits. Coordinated visits by employment specialist with integrated team member. Connect with family, when applicable. Once it is clear that the client no longer wants to work or continue SE services, the team stops outreach.	MIS, DOC, INT, OBS	1= Evidence that 2 or less strategies for engagement and outreach are used. 2= Evidence that 3 strategies for engagement and outreach are used. 3= Evidence that 4 strategies for engagement and outreach are used. 4= Evidence that 5 strategies for engagement and outreach are used. 5= Evidence that all 6 strategies for engagement and outreach are used: i) Service termination is not based on missed appointments or fixed time limits. ii) Systematic documentation of outreach attempts. iii) Engagement and outreach attempts made by integrated team members. iv) Multiple home/community visits. v) Coordinated visits by employment specialist with integrated team member. vi) Connect with family, when applicable.

*Data sources:

MIS	Management Information System
DOC	Document review: clinical records, agency policy and procedures
INT	Interviews with clients, employment specialists, mental health staff, VR counselors, families, employers
OBS	Observation (e.g., team meeting, shadowing employment specialists)
ISP	Individualized Service Plan

2/14/96
6/20/01, Updated
1/7/08, Revised

Supported Employment Fidelity Scale Score Sheet

Staffing		
1.	Caseload size	Score:
2.	Employment services staff	Score:
3.	Vocational generalists	Score:
Organization		
1.	Integration of rehabilitation with mental health thru team assignment	Score:
2.	Integration of rehabilitation with mental health thru frequent team member contact	Score:
3.	Collaboration between employment specialists and Vocational Rehabilitation counselors	Score:
4.	Vocational unit	Score:
5.	Role of employment supervisor	Score:
6.	Zero exclusion criteria	Score:
7.	Agency focus on competitive employment	Score:
8.	Executive team support for SE	Score:
Services		
1.	Work incentives planning	Score:
2.	Disclosure	Score:
3.	Ongoing, work-based vocational assessment	Score:
4.	Rapid search for competitive job	Score:
5.	Individualized job search	Score:
6.	Job development—Frequent employer contact	Score:
7.	Job development—Quality of employer contact	Score:
8.	Diversity of job types	Score:
9.	Diversity of employers	Score:
10.	Competitive jobs	Score:
11.	Individualized follow-along supports	Score:
12.	Time-unlimited follow-along supports	Score:
13.	Community-based services	Score:
14.	Assertive engagement and outreach by integrated treatment team	Score:
	Total:	

115 – 125	= Exemplary Fidelity
100 - 114	= Good Fidelity
74 – 99	= Fair Fidelity
73 and below	= Not Supported Employment

Appendix 3: Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) Services Rate Development

This section describes the methodology and assumptions used in developing the fee-for-service (FFS) rates for PROMISE services. The State contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to establish fees for these services.

Methodology

The fee schedule methodology consisted of a multi-pronged approach. The first step involved a check to determine if fee schedule rates existed in a current State Medicaid program for services that were comparable to the PROMISE services. If this was the case, then the existing Medicaid fee schedule rate for that comparable service was used. This held true for the following services:

- Nursing services (RN and LPN) — Fee schedule rates existed on the Division of Medicaid and Medical Assistance (DMMA) fee schedule for comparable Private Duty Nursing (PDN), Registered Nurse (RN), and Licensed Practical Nurse (LPN) services.
- Peer Supports — Fee schedule rate existed for the comparable Substance Use Disorder (SUD) Peer service.
- Personal Care, Instrumental Activities of Daily Living (IADL)/Chore, and Respite In-home — Fee schedule rate existed for the comparable Personal Care service under the PATHWAYS program; final rate was converted to a 15-minute unit instead of hourly basis.
- Benefits Counseling, Financial Coaching, and Small-group Supported Employment — Fee schedule rates existed under the PATHWAYS program for the comparable Benefits Counseling, Financial Coaching, and Short-Term Small Group Supported Employment (STSGSE) services, respectively.
- Non-medical Transportation (NMT) — See FFS fee schedule from Logisticare.

Where State Medicaid fee schedule rates for comparable services were not already in existence, the fees were developed using a market-based pricing methodology. This approach was used for Psychosocial Rehabilitation (PSR), Community Psychiatric Support and Treatment (CPST), Individual Employment Support Services (IESS), Residential, and Care Management services. Under this approach, assumptions were established for key cost components based on the service description to calculate the modeled fee ranges. The key steps in the process are highlighted below:

1. Review the service definition and identify key cost components.
2. Gather Delaware wage data to inform salary assumptions.
3. Conduct additional research to inform key assumptions.
4. Work with the State to finalize cost component assumptions.

Each of the steps is described in more detail in the subsequent paragraphs.

Step 1 — Review the Service Definition and Identify Key Cost Components

To develop the modeled fee ranges, the service definitions were reviewed for each service to understand the key requirements of the services, including provider qualifications, licensing

requirements, staffing requirements, and other general information related to delivery of each service.

Based on this review, the key cost components were identified to account for costs that were reasonable, necessary, and related to the delivery of the service.

The major cost components considered for each service were:

- Direct Care Costs — Salary expenses for the required staffing (i.e., the different positions and time requirements) at prevailing Delaware wages, adjusted to include consideration for Employee-Related Expenses (ERE) and productivity.
- Indirect Costs — Supervisory expenses and other program-related costs.
- Administrative costs.

Step 2 — Gather Delaware Wage Data to Inform Salary Assumptions

Based on the service definitions and State clinical practice reviews, appropriate staffing levels and positions for each service were determined. Compensation data was compiled from the Bureau of Labor Statistics for PSR, CPST, IESS, and Residential services. Since Care Management is currently provided by State employees, wages for this service were compiled from the State's Human Resources Management website. The data was representative of wages paid in the State of Delaware and was used to develop an annual wage range for each staffing position, as outlined below.

PROMISE Service	Staff Position	Annual Salary Range Fiscal Year 2014/2015
PSR	Direct Care Worker	$35,000–$49,000
	Supervisor	$65,000–$77,000
CPST	Direct Care Worker	$48,000–$66,000
	Supervisor	$65,000–$77,000
IESS	Direct Care Worker	$35,000–$49,000
	Supervisor	$65,000–$77,000
Residential — Group Homes	Certified Nursing Assistant	$25,000–$32,000
	Associate Clinician	$35,000–$49,000
	Nurse	$64,000–$84,000
	Psychiatrist	$168,000–$247,000
	Residence Manager	$48,000–$66,000
Residential — Supervised Apartments	Direct Care Worker	$24,000–$35,000
	Residence Manager	$48,000–$66,000
Care Management	Direct Care Worker	$38,000–$47,000
	Supervisor	$54,000–$68,000

Step 3 — Conduct Additional Research to Inform Key Assumptions

This section discusses the research findings and assumptions for ERE and program-related cost components.

ERE

In addition to wages, the following ERE components were considered for both the Direct Care and Indirect Care staff:

- Health Insurance (Medical, Dental, and Vision).
- Unemployment Taxes (Federal and State).
- Worker's Compensation.
- Federal Insurance Contribution Act Tax (FICA).
- Contributions for other benefits (e.g., Short-term Disability, Long-term Disability, Retirement).

The amounts included in the fees represent the employer's share of the costs for these items. For PSR, CPST, and IESS, approximately 20%–30% of the total wage amount was built in for the ERE cost component. This assumption was based on market data benchmarks. For Residential services, approximately 25%–35% of the total wage amount was built in for the ERE cost component. This was based on a review of market data, as well as historical residential provider invoices. Since Care Management is currently provided by State employees, ERE expenses for this service were compiled from the State's Human Resources Management website. Approximately 50%–60% of the total wage amount was built into the Care Management fee for the ERE cost component.

Other Program-related Costs

In addition to ERE, other program-related costs were considered including costs for training, accreditation, staff travel, supplies, occupancy, and administrative expenses. Based on the nature of the services, considerations differed for Residential services, so they are described separately in subsequent paragraphs.

PSR, CPST, Care Management, and IESS

Training Costs

Consideration was made for expenses related to standard training requirements outlined in the service descriptions. This was done consistently for PSR, CPST, Care Management, and IESS. Since IESS providers must meet certain fidelity requirements set forth by the Individual Placement and Support (IPS) model in order to render this service, additional costs were reflected in the IESS fees to account for the costs that would be incurred to obtain this accreditation.

Staff Travel

Consideration was included for staff travel expenses. The annual mileage for each service was estimated by taking an assumed number of miles traveled per day (based on discussions with the State) and multiplying by the total billable days worked each year. The resulting annual mileage was assumed to be paid at the Internal Revenue Service (IRS) standard mileage rate.

Service-related Supplies

Consideration was included for the cost of service-related materials or equipment that the provider would be required to have in order to deliver the service.

Occupancy

Costs associated with general occupancy expenses, such as office space used for the delivery of the service, were also considered in the fees. An occupancy cost was included for all services that are rendered in an office setting and not directly provided in the community.

Administration
Costs associated with general administrative expenses such as management, equipment and supplies, recruitment, information technology, human resources, billing, finance and accounting, legal, and other indirect costs necessary for program operations were also considered. The assumption was based on discussions with the State and the Center for Medicare and Medicaid Services expectations regarding acceptable levels for this cost component.

Residential Services (Group Home and Supervised Apartments)
Training, Staff Travel, and Supplies
Consideration was made for expenses related to standard training requirements outlined in the service descriptions. The fees also included consideration for staff travel expenses and service-related materials or equipment that the provider would be required to have in order to deliver the service. Historical residential provider invoices were reviewed to understand the amount that providers historically spent on these items, and these values were compared to market benchmarks for reasonability. Note that expenditures related to Room and Board were not included in the fee development process.

Administration
Costs associated with general administrative expenses such as management, equipment and supplies, recruitment, information technology, human resources, billing, finance and accounting, legal, and other indirect costs necessary for program operations were also considered. The assumption was based on a review of historical residential provider invoices and discussions with the State.

Step 4 — Work with the State to Finalize Key Cost Component Assumptions

PSR, CPST, Care Management, and IESS

Non-billable Time
For PSR, CPST, Care Management, and IESS, adjustments to account for non-billable staff time were also considered. Non-billable staff time includes time for training, paid time off (PTO), and a portion of each workday that is spent on usual and required non-billable activities. Consideration for this non-billable time was included in the fee through a productivity adjustment. The staffing cost (i.e., cost for Direct Care and Indirect Care staff) was adjusted by a factor that accounted for the total billable time relative to the total staff time.

Absentee Factor
An absentee factor was used to include consideration for the percentage of time that appointments are missed. Although missed appointments reduce the units of service that are delivered, the provider still needs to pay their Direct Care staff for their hours on the job. Please note that an absentee factor was not included for Care Management services.

Residential Services (Group Home and Supervised Apartments)
Vacancy Factor
To include consideration for days when the beneficiary is temporarily not in the residence (e.g., due to medical or therapeutic leave), a vacancy factor was included. This assumption was based on historical residential group home and supervised apartment vacancy rates and discussions with the State.

Fee Schedule Summary

Please see the service description section for the final fees selected by the State.

Limitations and Caveats

In preparing the fee ranges, Mercer considered publicly available market information, provider invoice data, and guidance from the State. We reviewed the data and information for internal consistency and reasonableness, but have not audited them. If the data or information is incomplete or inaccurate, the values may need to be revised accordingly. The following limitations apply to the development of the fee ranges:

- Fee schedule assumptions were based upon the PROMISE service descriptions that were approved effective December 19, 2014. When the service descriptions were not specific regarding a particular cost component, the applicable assumptions were developed in conjunction with the State.
- To the extent changes or clarifications are made to the service descriptions, fees may be impacted and need to be updated accordingly.
- Fee schedule assumptions were developed based upon information available as of December 2014.

Fees developed by Mercer are projections of future contingent events. Actual provider costs may differ from these projections. Mercer has developed these fees on behalf of the State to support the delivery of PROMISE services. Use of these fees for any purpose beyond that stated may not be appropriate.

Potential PROMISE fee schedule service providers are advised that the use of these fees may not be appropriate for their particular circumstance, and Mercer disclaims any responsibility for the use of these fees by providers for any purpose. Mercer recommends that any organization considering contracting with the State should analyze its own projected expenses and revenue needs for comparison to the fees offered by the State before deciding whether to contract with the State.

This methodology document assumes the reader is familiar with the PROMISE program and projection techniques. It is intended for the State and should not be relied upon by third parties. Other readers should seek advice of qualified professionals to understand the technical nature of these results. This document should only be reviewed in its entirety.

Delaware Intensive Case Management (ICM) and Assertive Community Treatment (ACT) Billing Guidance and Rate Development

ICM Billing Guidance

ICM 15-minute units may only be billed when the ICM practitioner has performed a medically necessary face-to-face service with the beneficiary or a family member for that time. Small ICM teams serve, on average, 100 or fewer beneficiaries. Large ICM teams serve, on average, 101–200 beneficiaries.

- ICM practitioners may only bill for a 15-minute unit if at least eight (8) minutes of service is provided.
- Group ICM contacts are not reimbursable.
- Practitioners may not bill for services included in the 15-minute units and also bill for that service outside of the 15-minute rate for consumers enrolled in ICM.
- All services require prior authorizations.

ICM Rate Summary (New Teams — First Year Rate) — 15 Minute Rate

Staff	Unit	Small Team	Large Team	Procedure Code
Team Lead and Masters Therapist	15 minutes	$35.42	$35.10	H0036 HO
Bachelors Therapist	15 minutes	$28.54	$28.22	H0036 HN
Peer/High School	15 minutes	$28.54	$28.22	H0036 HM
Doctor/Psychiatrist	15 minutes	$73.81	$73.63	H0036 AM
Advanced Practice Registered Nurse (APRN)	15 minutes	$38.60	$38.42	H0036 HP
Nurse	15 minutes	$22.42	$22.23	H0036 TD

ICM Rate Summary (Established Teams) — 15 Minute Rate

Staff	Unit	Small Team	Large Team	Procedure Code
Team Lead and Masters Therapist	15 minutes	$30.25	$29.93	H0036 HO
Bachelors Therapist	15 minutes	$24.47	$24.15	H0036 HN
Peer/High School	15 minutes	$24.47	$24.15	H0036 HM
Doctor/Psychiatrist	15 minutes	$60.49	$60.31	H0036 AM
APRN	15 minutes	$31.72	$31.54	H0036 HP
Nurse	15 minutes	$18.51	$18.31	H0036 TD

Licensed Direct Care staff must provide services within the scope of practice for their license under State law.

The following activities may not be billed or considered the activity for which the ICM 15-minute unit is billed and will be recouped if found in an audit:

- Contacts that are not medically necessary.
- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
- Habilitative services for the beneficiary (adult) to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to reside successfully in community settings.
- Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the beneficiary or family. Services provided in the car are considered Transportation and time may not be billed for ICM. Additional medical transportation for non-PROMISE service needs not considered part of ICM Program Services may be covered by the transportation broker through the State Plan. Medical transportation to ICM providers may not be billed to the transportation broker.
- Services provided to beneficiaries under age 18.
- Covered services that have not been rendered.
- Services provided before the department, or its designee (including the prepaid inpatient healthplan) has approved authorization.
- Services rendered that are not in accordance with an approved authorization.
- Services not identified on the beneficiary’s (adult's) authorized ICM participant-directed Recovery Plan or PROMISE Recovery Plan.

- Services provided without prior authorization by the department or its designee.
- Services not in compliance with the contract or the ICM provider certification service manual.
- Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not listed on the eligible beneficiary's ICM participant-directed Recovery Plan or PROMISE Recovery Plan.
- Services provided that are not within the provider's scope of practice.
- Any art, movement, dance, or drama therapies.
- Anything not included in the approved ICM service description.
- Changes made to ICM that do not follow the requirements outlined in the provider contract and provider certification service manual.
- Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services will not be reimbursed.
- Employment of the beneficiary. Under the PROMISE HCBS program, ICM includes non-job specific vocational training, employment assessments, and ongoing support to maintain employment. ACT may also pay for the Medical services that enable the beneficiary to function in the workplace, including ACT services such as a psychiatrist's or psychologist's treatment, rehabilitation planning, therapy, and counseling that enable the beneficiary to function in the workplace. Note: if Supported Employment is separately listed on the beneficiary's Recovery Plan as a covered PROMISE service, qualified bachelor's level practitioners enrolled as Employment Specialists under PROMISE may bill for one bachelor's level per diem rate per month of Supported Employment after the Vocational Rehabilitation Job Placement services (typically 90-days after placement) are exhausted.

ACT Billing Guidance

ACT per diems may only be billed on days when the ACT team has performed a face-to-face service with the beneficiary or a family member. Only one per diem per category of practitioner type on each team may be billed per beneficiary per day. All other contacts, meetings, travel time, etc., are considered indirect costs and are accounted for in the build-up of the per diem rate. Small ACT teams serve, on average, 70 or fewer beneficiaries. Large ACT teams serve, on average, 71–100 beneficiaries but no more than 125.

- For an ACT team per diem to be generated, a 15-minute or longer face-to-face contact that meets all requirements outlined below must occur. A 15-minute contact is defined as lasting at least eight (8) minutes. Group contacts alone are not permitted as a face-to-face contact for generating an ACT per diem rate.
- ACT practitioners using a 15-minute unit rate, may only bill for a 15-minute unit if at least eight (8) minutes of services is provided.
- Group ACT contacts are not reimbursable.
- Practitioners may not bill for services included in the ACT per diem or 15-minute units and also bill for that service outside of the per diem/15-minute rate for enrolled beneficiaries.
- All services require prior authorizations.
- The Psychiatric prescriber shall be physically located at the home clinic of the ACT team in order to provide office-based services and services in the community when indicated.
- With the prior approval of the Division of Substance Abuse and Mental Health (DSAMH), Psychiatric prescribers may be accessed via videoconferencing/tele-psychiatry consistent with

State tele-medicine requirements for a period of up to six (6) months. At DSAMH's discretion, DSAMH may extend this authorization for an additional six (6) months.[11]

Non-Fidelity ACT Rate Level

A team that does not have an ACT provisional, basic, moderately high-, or high-level fidelity rating (see definitions below) can only bill at the non-fidelity ACT rate.

Provisional Fidelity Level

A new ACT team can be certified at a provisional fidelity level for six (6) months if it has submitted the required documentation to the DSAMH Quality Assurance Unit. At that time, the ACT team must undergo a mock fidelity review by DSAMH and achieve an average Tools for Measurement of Assertive Community Treatment (TMACT) fidelity score of 2.0 or greater. In order to achieve a provisional fidelity level, the team must also achieve minimum fidelity rating scores on certain aspects of TMACT fidelity:

- A minimum average rating of 3.0 across the following items from the operations and structure (OS) subscale must be achieved:
  - OS1 — Low ratio of beneficiaries to staff.
  - OS5 — Program size.
  - OS6 — Priority service population.
  - OS10 — Retention rate.
- A minimum average rating of 3.0 on the entire core team (CT) subscale must be received.
- A minimum rating of 3.0 on core practices (CP) subscale CP1 — community-based services item must be received.

A team meeting provisional fidelity will be able to be reimbursed at the basic fidelity level for up to one (1) year from the date of its initial provisional fidelity level certification. During the year following the provisional fidelity level certification, the team must comply with DSAMH requirements to carry out a full fidelity assessment and achieve a fidelity rating of at least basic level fidelity. After 12 months from the provisional fidelity level certification date, if the team has failed to meet at least basic level fidelity, it will revert to the non-fidelity ACT billing rate. At any time during the 12-month period of provisional fidelity level certification, DSAMH can request additional information to assess any questions that may arise regarding any TMACT fidelity metric. At the time of request, all subsequent billing will be pended subject to verification of the identified TMACT fidelity metric. If the additional review reveals that the fidelity score for any identified metric falls below a 1.0, the team will have 90 days to demonstrate capacity at a level above 1.0 for each identified metric. If such capacity is not demonstrated to the satisfaction of DSAMH, billing will revert to the non-fidelity ACT level for all pending and future services until at least basic fidelity level is achieved on those identified metrics.

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11 Consultations, office visits, individual psychotherapy, and pharmacological management services under ACT prescriber- as outlined above for the time granted by the waiver only-may be reimbursed when provided via Health Insurance Portability & Accountability Act compliant telecommunication technology. The consulting or expert physician must bill the ACT procedure code (CPT codes) using the GT modifier and will be reimbursed at the same rate as a face-to-face service for ACT physician. The originating site, with the consumer present, may bill code Q3014 (telemedicine originating site facility fee). Providers must follow all applicable federal and State security and procedure guidelines for telemedicine. Face-to-face ACT includes a therapist in a different room/location from the client/family, but in the same building, with real-time visual and audio transmission from the therapy room and two-way audio transmission between client and/or family member and therapist. The practice must be in accord with documented evidence-based practices of ACT as approved by DSAMH. If not in the same building, then telemedicine requirements and reimbursement would apply. Telemedicine services must comply with Delaware's telemedicine requirements including, but not limited to:

- Obtaining member's written consent;
- Licensure and enrollment requirements;
- Written contingency planning;
- Implementation of confidentiality protocols; and
- Billing practices and requirements.

Once the year of provisional fidelity is completed, DSAMH may place any ACT team not reaching basic fidelity on a corrective action plan, not to exceed 90 days. During that time, the team may bill ACT rates. If the team is not at basic fidelity at that time, the team must bill non-fidelity ACT rates until basic fidelity is achieved.

Basic Fidelity Level

ACT teams scoring an overall TMACT fidelity score of at least 3.0 may bill for up to four (4) per diems per month per beneficiary when all other requirements for a visit are met (i.e., a face-to-face service with the beneficiary or family member). *Medically necessary care consistent with the fidelity model should be delivered even if beyond the minimum number of units permitted to be billed under this reimbursement strategy.* The team must also achieve the following minimum fidelity rating scores on certain aspects of TMACT fidelity:

- A minimum average rate of 3.0 across the following items from the OS subscale must be achieved:
  - OS1 — Low ratio of beneficiaries to staff.
  - OS5 — Program size.
  - OS6 — Priority service population.
  - OS10 — Retention rate.
- A minimum average rating of 3.0 on the CT subscale must be received.
- A minimum rating of 3.0 on CP subscale CP1 — community-based services item must be received.
- At any time during the 12-month period of basic fidelity level certification, DSAMH can request additional information to assess any questions that may arise regarding any TMACT fidelity metric. At the time of request, all subsequent billing will be pended subject to verification of the identified TMACT fidelity metric. If the additional review reveals that the fidelity score for any identified metric falls below the standards for OS, CT, and CP1 listed above, the team will have 90 days to demonstrate capacity at a level above the required minimums for each identified metric. If such capacity is not demonstrated to the satisfaction of DSAMH, billing will revert to the non-fidelity ACT level for all pended and future services until at least basic fidelity level is achieved on those identified metrics.

  Practitioners on the ACT teams are subject to the following billing limits per category per month per beneficiary, not to exceed a total of four (4) per diems (as defined above) per beneficiary in total from any combination of practitioners (Note: the billing must be based on actual services provided to the beneficiary and *medically necessary care consistent with the fidelity model should be delivered even if beyond the minimum number of units permitted to be billed under this reimbursement strategy.*):

  - Category 1: Physicians and APRNs may not bill more than one (1) per diem for a beneficiary per month in total.
  - Category 2: Any combination of Psychologist, master's level, Team Leader, LCSW, LPC, LMFT, LAC, behavioral health other, RN, and LPN may not bill more than one (1) per diem for a beneficiary in a monthly total. Ideally, this visit will not be in a clinic setting.
  - Category 3: All other practitioners on the ACT teams may bill up to two (2) per diems for a beneficiary in a monthly total. Ideally, these visits will not be in a clinic setting.

Note: Only one practitioner across all categories may bill on the same day (e.g., only one per diem can be billed on a given day). IESS provided by an ACT team requires prior authorization and is billed only when Supported Employment goals and activities are specifically outlined on the beneficiary's Recovery Plan. The team may bill up to one extra bachelor's level unit (i.e., 5th per diem) for the team Vocational Specialist per month when vocational activities were conducted with the team consistent with the TMACT fidelity model. Documentation must be maintained regarding the vocational activities performed and the goals/activities completed for each individual in the beneficiary's medical record.

Moderately High-Fidelity Level

ACT teams scoring an overall TMACT fidelity score of at least 3.5 when all other requirements are met (i.e., a face-to-face service with the beneficiary or family member) are considered moderately high fidelity. In addition to the average score, teams must meet the following specific TMACT requirements:

- A minimum average rate of 3.5 across the following items from the OS subscale must be achieved:
  - OS5 — Program size.
  - OS6 — Priority service population (which must be at least 4).
  - OS9 — Transition to less Intensive services.
  - OS10 — Retention rate.
- A minimum average rating of 4 on the CT subscale must be received.
- A minimum rating of 4 on CP subscale CP1 — community-based services item must be received.
- A minimum average rating of 3 on the person-based planning (PP) subscale must be received.
- At any time during the 12-month period of moderately high fidelity level certification, DSAMH can request additional information to assess any questions that may arise regarding any TMACT fidelity metric. At the time of request, all subsequent billing will be pended subject to verification of the identified TMACT fidelity metric. If the additional review reveals that the fidelity score for any identified metric falls below the standards for OS, CT, CP1, and PP listed above, the team will have 90 days to demonstrate capacity at a level above the required minimums for each identified metric. If a team meets moderately high fidelity, DSAMH may consider permitting additional per diems via prior authorization as necessary to meet moderately high-fidelity standards. However, if such capacity is not demonstrated to the satisfaction of DSAMH, billing will revert to the basic level for all pended and future services until at least moderately high-fidelity level is achieved on those identified metrics.

High Fidelity Level

ACT teams scoring a TMACT fidelity score of at least 4.2 when all other requirements are met (i.e., a face-to-face service with the beneficiary or family member) is considered high fidelity. In addition, teams must meet the following specific TMACT requirements (similar to Level 2 teams):

- A minimum average rate of 4 across the following items from the OS subscale must be achieved:
  - OS5 — Program size.
  - OS6 — Priority service population (this item must score a 5).
  - OS9 — Transition to less Intensive services.
  - OS10 — Retention rate.
- A minimum average rating of 4 on the CT subscale must be received.
- A minimum rating of 4 on CP1 – community-based services item must be received.

- A minimum average rating of 3.7 on the following subscales:
  - PP subscale.
  - Specialist team subscale.
  - Evidence-based Practice (EBP) subscale.
- At any time during the 12-month period of high-fidelity level certification, DSAMH can request additional information to assess any questions that may arise regarding any TMACT fidelity metric. At the time of request, all subsequent billing will be pended subject to verification of the identified TMACT fidelity metric. If the additional review reveals that the fidelity score for any identified metric falls below the standards for OS, CT, CP1, PP, specialist, and EBPs listed above, the team will have 90 days to demonstrate capacity at a level above the required minimums for each identified metric. If a team meets high fidelity, DSAMH may consider permitting additional per diems via prior authorization as necessary to meet high fidelity standards. However, if such capacity is not demonstrated to the satisfaction of DSAMH, billing will revert to the Basic level for all pended and future services until at least moderately high- or high-fidelity level is achieved on those identified metrics.

ACT Rate Summary (New Teams — First Year Rate with Provisional Cert) — Per Diem Rate

Staff	Unit	Small Team	Large Team	Procedure Code
Team Lead and Masters Therapist	Per Diem	$ 208.21	$195.91	H0040 HO
Bachelors Therapist	Per Diem	$ 177.04	$165.80	H0040 HN
Peer/High School	Per Diem	$ 170.88	$159.83	H0040 HM
Doctor/Psychiatrist	Per Diem	$ 685.11	$658.31	H0040 AM
Nurse Practitioner/APRN	Per Diem	$ 518.71	$496.96	H0040 HP
RN	Per Diem	$ 256.54	$242.74	H0040 TD

ACT Rate Summary (Established Teams) — Per Diem Rate

Staff	Unit	Small Team	Large Team	Procedure Code
Team Lead and Masters Therapist	Per Diem	$197.09	$187.15	H0040 HO
Bachelors Therapist	Per Diem	$167.59	$158.39	H0040 HN
Peer/High School	Per Diem	$161.76	$152.69	H0040 HM
Doctor/Psychiatrist	Per Diem	$648.54	$628.90	H0040 AM
Nurse Practitioner/APRN	Per Diem	$491.03	$474.76	H0040 HP
RN	Per Diem	$242.85	$231.89	H0040 TD

ACT Rate Summary (New Teams — First Year) — 15 Minute Rate

Staff	Unit	Small Team	Large Team	Procedure Code
Team Lead and Masters Therapist	15 minutes	$54.25	$52.59	H0039 HO
Bachelors Therapist	15 minutes	$43.97	$42.37	H0039 HN
Peer/High School	15 minutes	$43.97	$42.37	H0039 HM
Doctor/Psychiatrist	15 minutes	$140.42	$139.24	H0039 AM
Nurse Practitioner/APRN	15 minutes	$75.72	$74.54	H0039 HP
RN	15 minutes	$42.69	$41.51	H0039 TD

ACT Rate Summary (Established Teams) — 15 Minute Rate

Staff	Unit	Small Team	Large Team	Procedure Code
Team Lead and Masters Therapist	15 minutes	$29.49	$28.53	H0039 HO
Bachelors Therapist	15 minutes	$24.29	$23.35	H0039 HN
Peer/High School	15 minutes	$23.46	$22.52	H0039 HM
Doctor/Psychiatrist	15 minutes	$114.00	$113.03	H0039 AM
Nurse Practitioner/APRN	15 minutes	$61.60	$60.74	H0039 HP
RN	15 minutes	$35.01	$34.04	H0039 TD

Non-Fidelity ACT Rate Summary (New Teams — First Year) — Per Diem Rate

Staff	Unit	Small Team	Large Team	Procedure Code
Team Lead and Masters Therapist	Per Diem	$ 197.80	$186.11	H0037 HO
Bachelors Therapist	Per Diem	$ 168.19	$157.51	H0037 HN
Peer/High School	Per Diem	$ 162.33	$151.84	H0037 HM
Doctor/Psychiatrist	Per Diem	$ 650.85	$625.39	H0037 AM
Nurse Practitioner/APRN	Per Diem	$ 492.78	$472.11	H0037 HP
RN	Per Diem	$ 243.72	$230.60	H0037 TD

Non-Fidelity ACT Rate Summary (Established Teams) — Per Diem Rate

Staff	Unit	Small Team	Large Team	Procedure Code
Team Lead and Masters Therapist	Per Diem	$187.24	$177.80	H0037 HO
Bachelors Therapist	Per Diem	$159.21	$150.47	H0037 HN
Peer/High School	Per Diem	$153.67	$145.05	H0037 HM
Doctor/Psychiatrist	Per Diem	$616.11	$597.45	H0037 AM
Nurse Practitioner/APRN	Per Diem	$466.48	$451.02	H0037 HP
RN	Per Diem	$230.71	$220.30	H0037 TD

Licensed Direct Care staff must provide services within the scope of practice for their license under State law.

The following activities may not be billed or considered the activity for which the ACT 15 minute/per diem is billed and recouped if found in an audit:

- Contacts that are not medically necessary.
- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
- Habilitative services for the beneficiary (adult) to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to reside successfully in community settings.
- Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the beneficiary or family. Services provided in the car are considered Transportation and time may not be billed for ACT. Additional medical transportation for non-PROMISE service needs not considered part of ACT Program Services may be covered by the

transportation broker through the State Plan. Medical transportation to ACT providers may not be billed to the transportation broker.
- Services provided to beneficiaries under age 18.
- Covered services that have not been rendered.
- Services provided before the department, or its designee (including the prepaid inpatient healthplan) has approved authorization.
- Services rendered that are not in accordance with an approved authorization.
- Services not identified on the beneficiary's authorized ACT participant-directed Recovery Plan or PROMISE Recovery Plan.
- Services provided without prior authorization by the department or its designee.
- Services not in compliance with the contract or the ACT service manual and not in compliance with fidelity standards.
- Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not listed on the eligible beneficiary's ACT participant-directed Recovery Plan or PROMISE Recovery Plan.
- Services provided that are not within the provider's scope of practice.
- Any art, movement, dance, or drama therapies.
- Anything not included in the approved ACT service description.
- Changes made to ACT that do not follow the requirements outlined in the provider contract, service manual, or ACT fidelity standards.
- Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services will not be reimbursed.
- Employment of the beneficiary. Under the PROMISE HCBS program, ACT includes non-job specific vocational training, employment assessments, and ongoing support to maintain employment. ACT may also pay for the medical services that enable the beneficiary to function in the workplace, including ACT services such as a psychiatrist's or psychologist's treatment, rehabilitation planning, therapy, and counseling that enable the beneficiary to function in the workplace. Note: if Supported Employment is separately listed on the individuals Recovery Plan as a covered PROMISE service, qualified bachelor's level practitioners enrolled as Employment Specialists under PROMISE may bill for one (1) bachelor's level per diem rate per month of Supported Employment after the Vocational Rehabilitation Job Placement services (typically 90-days after placement) are exhausted.

ACT Rate Development

This document describes the methodology and assumptions used in developing the rates for ACT. The proposed rates establish separate rates for practitioners with similar licensure/educational requirements. The State contracted with Mercer to establish rates for these services.

Methodology

Rates were developed using a market-based pricing methodology for each service. Under this approach, assumptions were established for key cost components based on the service description to calculate the modeled rate. The key steps in the process are highlighted below:

1. Review the service definitions and identify key cost components.
2. Evaluate budget data submitted by ACT providers.
3. Conduct additional research to inform key assumptions.
4. Work with the State to finalize key pricing assumptions.

Step 1 — Review the Service Definitions and Identify Key Cost Components

To develop the modeled rates, we first established an understanding of the staffing requirements for each service. From the service definition and a review of clinical practices, we determined the appropriate staff positions:

- Team Lead — Licensed Mental Health Professional, master's degree.
- Therapists — bachelor's or master's level staff.
- Peer/High School Level — High school level degree or GRE.
- Doctor/Psychiatrist — Licensed Board Certified Psychiatrist.
- APRN — Licensed Nurse Practitioner.
- Nurse — Licensed RN.

The average numbers of full-time employees (FTEs) for each level of staff reflected in the ACT rates are below in Table 1. Note that separate staffing levels were used for large and small team rates. Small ACT teams may serve no more than 70 beneficiaries. Large ACT teams may serve no more than 100 beneficiaries.

Table 1: Staffing Summary[12]

Staff	Small Team	Large Team
Team Lead	1 FTE	1 FTE
Masters Therapist	2 FTEs	2 FTEs
Bachelors Therapist	1.3 FTEs	2 FTEs
Peer/High School	1 FTE	1 FTE
Doctor/Psychiatrist or APRN	0.5 FTE	1 FTE
Nurse	1.5 FTEs	3 FTEs (one FTE must be a bachelor's)

NOTE: Providers may choose to have three (3) RN FTE's and two (2) Bachelors FTEs with one (1) of the RN's having a Bachelor's Degree or two (2) RN FTE's and three (3) Bachelors FTEs (one (1) could also be a RN).

Cost Components

The modeled rates considered the following key cost components:

- Salary expenses for the required staffing (i.e., the different positions and time requirements) at prevailing Delaware wages, adjusted to include consideration for ERE and productivity.
- Indirect non-salary, program-related costs.
- Administrative costs.

Step 2 — Gather Wage Data for Delaware

To estimate the cost of the staffing requirements identified above, Mercer gathered compensation data from proposed budgets for ACT providers. The data should be representative of wages paid in Delaware and was used to develop a wage for each staffing position.

[12] TMACT also assumes a Program Assistant working with the ACT team. It is covered under administrative expenses below though not explicitly since it is grouped together with all other administrative costs.

However, in the case of the Nurse Practitioner position, we did not receive compensation data from the proposed budgets, and thus used a wage study from the American Academy of Nurses. We proposed using the average base salary for a Nurse Practitioner in the Psychiatric/Mental Health field. However, since this was a national average, Mercer applied a regional analysis factor to adjust this wage upward.

Mercer performed reasonability checks of the wages by comparing these to compensation studies of similar positions in nearby states. Also, trend was considered to adjust the wage to the current time period.

The wage assumptions for the different levels of staff are summarized in Table 2.

Table 2: Hourly Wage Summary

Staff	Wage
Team Lead	$24.14
Masters Therapist	$21.97
Bachelors Therapist	$18.06
Peer/High School	$17.12
Doctor/Psychiatrist	$93.50
APRN	$64.00
Nurse	$29.93

Step 3 — Conduct Additional Research to Inform Key Assumptions

This section discusses the research findings and assumptions for ERE and program-related cost components.

ERE

In addition to wages, the following ERE components were considered for both the Direct Care and Indirect Care staff:

- Health Insurance.
- Unemployment Taxes (Federal and State).
- Worker’s Compensation Insurance.
- FICA.
- Other Benefits (short-term disability, long-term disability, and retirement).

The amounts included in the rates represent the employer’s share of the costs for these items. The ERE cost component was approximately 20% to 35% of the total wages amount, depending on staff position.

Other Program-related Costs

In addition to ERE, other program-related costs were considered including costs for training, fidelity, consultation, staff travel, and administrative expenses.

Training, Fidelity, and Consultation

Consideration was made for standard expenses (including registration, material, and travel) for ongoing and initial training, fidelity, and consultation.

Staff Travel and Beneficiary Transportation
The ACT rates include consideration for staff travel and beneficiary transportation expenses. The annual mileage for this service was estimated by taking an assumed number of miles traveled per day (based on discussions with the State) and multiplying by the total billable days worked each year. The resulting annual mileage was assumed to be paid at the IRS standard mileage rate.

Administration Expenses
Costs associated with general administrative expenses such as management, equipment and supplies, recruitment, information technology, human resources, billing, finance, and accounting, legal and other indirect costs necessary for program operations were also considered. The assumption was based on discussions with the State.

Step 4 — Work with the State to Finalize Key Pricing Assumptions
This section discusses the key consideration reflected in the assumptions for the remaining cost components.

Productivity Adjustments
For ACT, adjustments to account for non-billable staff time were also considered. Non-billable staff time includes time for training, PTO, and a portion of each workday that is spent on usual and required non-billable activities. Consideration for this non-billable time was included in the rate through a productivity adjustment. The staffing cost (i.e., cost for Direct Care and Indirect Care staff) was adjusted by a factor that accounted for the total billable time relative to the total staff time.

Fee Schedule Summary
Please see the ACT/ICM Billing Guidance section for the final fees selected by the State.

Limitations and Caveats
In preparing the fee ranges, Mercer considered publicly available market information, provider invoice data, and guidance from the State. We reviewed the data and information for internal consistency and reasonableness, but have not audited them. If the data or information is incomplete or inaccurate, the values may need to be revised accordingly.

Fees developed by Mercer are projections of future contingent events. Actual provider costs may differ from these projections. Mercer has developed these fees on behalf of the State to support the delivery of ACT/ICM services. Use of these fees for any purpose beyond that stated may not be appropriate.

Potential ACT/ICM fee schedule service providers are advised that the use of these fees may not be appropriate for their particular circumstance, and Mercer disclaims any responsibility for the use of these fees by providers for any purpose. Mercer recommends that any organization considering contracting with the State should analyze its own projected expenses and revenue needs for comparison to the fees offered by the State before deciding whether to contract with the State.

This methodology document assumes the reader is familiar with the ACT/ICM program and projection techniques. It is intended for the State and should not be relied upon by third parties. Other readers should seek advice of qualified professionals to understand the technical nature ofthese results. This document should only be reviewed in its entirety.