Provider Specific Policy for Home and Community Based Services Provided Under the DDDS Lifespan Waiver for Persons with Intellectual Developmental Disabilities

Revision Table

Revision Date	Sections Revised	Description
09/01/14	All	The manual was rewritten to bring it up to date with the services covered under the DDDS HCBS waiver as approved by CMS effective July 1, 2014. Revisions were also made to clarify that the manual applies to DDDS Home and Community Based Services covered under both the DDDS HCBS waiver and under the State Plan Rehabilitative Services Option unless otherwise specified. The term "Developmental Disability" was replaced with "Intellectual Developmental Disability".
09/01/14	2.0, 2.5, 4.0, 4.6	Supported Living was added as a new waiver service effective July 1, 2014 as approved by CMS in the renewal of the DDDS waiver.
06/15/2015	2.0	Language was added to the manual to reflect the new CMS Definition of Community Rule that applies to all Medicaid-funded Home and Community Based Services that became effective on March 17, 2014.
06/15/2015	2.0	Language was added to this section to define acceptable practices for the establishment of a provider “waiting list” to take referrals when they are at capacity.
06/15/2015	7.0	U1, was added as a required modifier to be used when billing Individual Supported Employment
08/1/2018	All	The manual was rewritten to bring it up to date with the additional waiver services added effective July 1, 2017 as approved by CMS in the Lifespan Amendment to the DDDS Lifespan Waiver; the waiver was renamed the “DDDS Lifespan Waiver”

Provider Specific Policy for Home and Community Based Services Provided Under the DDDS Lifespan Waiver for Persons with Intellectual Developmental Disabilities

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Provider Specific Policy for DDDS Lifespan Home and Community Based Waiver and State Plan Rehabilitative Services for Persons with Intellectual Developmental Disabilities

Home and Community-Based Services (HCBS) provided under the DDDS 1915(c) waiver provided to persons with developmental disabilities who are receiving residential habilitation are "carved out" of the managed care benefit package and are reimbursed on a "fee-for-service" basis. Medicaid covered health care services are provided to most Delaware Medicaid recipients through a Managed Care Organization (MCO), including individuals who receive their DDDS day services under the State Plan Rehabilitative Services Option. DMMA has amended the 1115 waiver to allow concurrent operation with the DDDS 1915 c Lifespan waiver in order to enable Lifespan waiver enrollees who live with their family or in their own home to receive their non-waiver benefits from the MCOs.

1.0 Overview

Delaware's application to provide home and community-based services to individuals with developmental disabilities was initially approved by the Center for Medicare and Medicaid Services (CMS) and became effective on July 1, 1983. The waiver is operated by the Delaware Division of Developmental Disabilities Services (DDDS) under a Memorandum of Understanding with the Delaware Division of Medicaid and Medical Assistance (DMMA). The waiver provides support services necessary to maintain individuals in the community as an alternative to institutionalization. By statute, the aggregate cost of the home and community-based services under the waiver cannot exceed the estimated cost of care in an Intermediate Care Facility for individuals with intellectual disability (ICF/IID). This is referred to as waiver "budget neutrality".

Consumer Choice

Waiver members may obtain Medicaid services, including waiver services, from any qualified provider enrolled in the Delaware Medicaid program to provide specific services per section 1902(a) (23) of the Social Security Act.

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2.0 Qualified Providers

Per the Memorandum of Understanding between DDDS and DMMA, DMMA has delegated the functions of developing provider standards and certifying that providers meet those standards to DDDS. After DDDS has determined that a provider is qualified, they are referred to DMMA's fiscal agent for enrollment into the Delaware Medicaid Assistance Program (DMAP). As part of that enrollment process, providers sign a contract with DMAP. Providers agree to comply with the program standards contained in this manual under that contract. In addition to the DMAP standards included in this manual, DDDS may also have state contracts with providers to identify additional state requirements that the providers must meet for specific services. In order to be a qualified provider, the provider must demonstrate compliance with the CMS HCBS Settings Rule. Examples of such additional requirements are the submission of data reports and the use of a specific electronic case record system to record data about DDDS consumers. DDDS may also have state contracts with providers to pay for services described in this manual for DDDS consumers who are not eligible for Medicaid.

Consumer Choice of Provider

By enrolling with DMAP to become a Medicaid waiver service provider, providers agree to provide service to any waiver member who chooses them to provide a service, unless they are at capacity or if the provider cannot or can no longer safely support a DDDS Lifespan Waiver member. If this occurs, the provider must provide a written explanation of why they cannot safely serve the member and participate in the development of a team risk mitigation plan. If the provider is already supporting the waiver member, and can no longer safely support the person, the provider must continue to provide services at the current authorized level of support while the team develops a transition plan. Providers must honor consumer choice. If the consumer expresses a desire to change providers, the provider will continue to provide services to the consumer as authorized and will assist with the development of a transition plan until the consumer has transitioned to the new service or service provider.

Provider Waiting Lists

Providers will only accept referrals from prospective service recipients who are requesting services to begin within 90 days of the application date. If a provider is at capacity, it may continue to take applications from waiver members. Providers who have reached capacity within a program or service shall notify DDDS in writing within five (5) business days of making the determination that capacity has been reached. DDDS will update the list of Authorized Providers on the DDDS website to reflect that the provider's program or service is at capacity. The providers may continue to accept referrals from prospective service recipients during the time their program or service is at capacity. For any referrals received while the program or service is at capacity, the provider shall establish a waiting list for each service and a protocol that describes how the waiting list will be managed. When the provider is no longer at capacity, it will process the individuals on the waiting list based on the date the referral/application is received in writing. The provider will ensure a "first come – first served" selection order.

Providers will notify DDDS in writing when the program or service is no longer at capacity. DDDS will update the website to reflect the program or service is no longer at capacity. Providers will only accept referrals from prospective service recipients who are requesting services to begin within 90 days of the application date.

CMS HCBS Settings Rule

CMS published a new Rule regarding HCBS Settings that became effective on March 17, 2014. The Rule applies to home and community-based services under the authorities of sections 1915(c), 1915(k) or 1915(i) of the Social Security Act (SSA).

The DDDS Lifespan Waiver is established under section 1915(c) of the SSA, so the settings in which DDDS Lifespan Waiver members live and the settings in which they receive other HCB services must comply with the new Rule. The HCB settings requirements can be found at 42 CFR 441.710(a)-(b).

HCB settings and services must meet the following criteria in order to be compliant with HCBS settings requirements:

- The setting is integrated in and facilitates access to the community.
- The setting facilitates interaction with non-disabled, non-Medicaid individuals.
- The provider meets all qualifications prior to service delivery including training that emphasizes participant rights, privacy, dignity, and respect.
- Provider offices and worksites may be inspected as part of the provider certification process.
- The setting optimizes but does not regiment individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- The setting facilitates individual choice regarding services and supports, and who provides them.

Because the DDDS waiver existed prior to the effective date of the CMS HCBS Settings Rule, any services and settings that are evaluated as not being compliant with the new Rule have until March 17, 2022 to fully comply with the Rule. The Delaware Division of Medicaid and Medical Assistance has submitted a Statewide Transition Plan to CMS that explains how Delaware will evaluate HCB services and settings against the Rule and how Delaware will come into compliance by March 17, 2022. Any new services or settings added after the effective date must be fully compliant with the Rule.

DDDS Provider Qualification Process

The DDDS Authorized Provider Committee is the entity that determines whether most waiver provider types meet the provider qualification standards that will enable them to deliver support services to DDDS Lifespan Waiver members and other consumers. Once enrolled, all providers are subject to review under the division's quality monitoring and improvement system, which is required by CMS for all home and community-based services. Metrics are established and

monitored in areas such as fulfillment of person-centered plans and individual service plans, the quality of service delivery, outcome achievement, maintenance of initial provider standards on an on-going basis, consumer health and welfare, compliance with documentation and financial requirements.

Provider agencies must demonstrate that they have the capacity and the infrastructure necessary to provide direct support to individuals with intellectual developmental disabilities. This includes having a governing body and management structure to:

- Establish internal policies and procedures consistent with DDDS service delivery standards;
- Acquire and maintain an adequate workforce of qualified individuals who meet the hiring and training requirements as specified by DDDS;
- Establish appropriate performance standards for employees hired by the provider;
- Establish an internal grievance/complaint procedure for all aspects of care;
- Develop a site-specific emergency preparedness plan for facility/site-based services;
- Maintain documentation to support the provision of authorized service and claims processing;
- Manage a quality assurance and improvement process that ensures that consumer outcome measures are met, as specified in the person-centered plan; and
- Maintain the health and safety of consumers.

Excluded Providers

The Office of Inspector General (OIG) of the U.S. Department of Health and Human Services has the authority to exclude individuals and entities from Federally funded health care programs pursuant to sections 1128 and 1156 of the Social Security Act and maintains a list of all currently excluded individuals and entities called the List of Excluded Individuals and Entities (LEIE). Anyone who hires an individual or entity on the LEIE may be subject to civil monetary penalties (CMP). In addition, the Patient Protection Affordable Care Act requires States to deny or terminate enrollment to providers that have been terminated from another State's Medicaid or CHIPS program.

Mandatory exclusions: The OIG is required by law to exclude from participation in all Federal health care programs individuals and entities convicted of the following types of criminal offenses: Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare, Medicaid, SCHIP, or other State health care programs; patient abuse or neglect; felony convictions for other health care-related fraud, theft, or other financial misconduct; and felony convictions relating to unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

To avoid CMP liability, health care entities need to routinely check the LEIE to ensure that new hires and current employees are not on the excluded list.

The OIG exclusions list can be found on the OIG website.

http://oig.hhs.gov/exclusions/index.asp

2.1 Day Services

General Qualifications of Day Program Staff

Day Service Program staff shall demonstrate an understanding of the needs and characteristics of persons with intellectual developmental disabilities through appropriate academic and programmatic accomplishments. All Day Service Program staff must have a background check consistent with DDDS Qualified Provider Standards and possess a valid Driver's License if transporting consumers.

Day Service Program staff must be thoroughly familiar with their assigned duties and responsibilities; including the types of services that they will facilitate. Duties shall be made available to each staff member.

Program administrators must have a degree in the human service area and/or experience with persons with intellectual development disabilities.

Day Habilitation Services: Facility, Non-Facility, Community Participation

- Must adhere to all standards, policies, and guidelines in the DDDS Purchase of Service Contract including the DDDS HCBS Waiver Certification Standards.
- All Direct Support Professional staff must meet all training requirements and timeframes for training completion and as specified in the DDDS Training Policy.
- Must be certified as a provider of Day Habilitation Service by the Division of Developmental Disabilities Services by demonstrating the competencies and capacity to provide day services as described in Section 4.0 of this manual to individuals with intellectual disabilities.
- In order to provide Community Participation Service, the provider must certified as a provider of Day Habilitation Service.
- Must be capable of delivering Community Participation Service in staffing ratios of no more than 1:2.

Prevocational Service

- Must adhere to all standards, policies, and guidelines in the DDDS Purchase of Service Contract including the DDDS HCBS Waiver Certification Standards.
- If consumers are paid a sub-minimum wage during the provision of a Prevocational service, the service center must be certified by the U.S. Department of Labor as a Work Activity Center as defined in Section 14(c) of the Fair Labor Standards Act.
- All Direct Support Professional staff must meet all training requirements and timeframes for training completion and as specified in the DDDS Training Policy.
- Must be certified as a Prevocational Service provider by the Division of Developmental Disabilities Services by demonstrating the competencies and

capacity to provide Prevocational services as described in Section 4.0 of this manual to individuals with intellectual disabilities.

2.2 Employment Services

Supported Employment - Individual and Small Group (provider qualifications are the same for these two services)

- Must adhere to all standards, policies, and guidelines in the DDDS Purchase of Service Contract including the DDDS HCBS Waiver Certification Standards.
- All Direct Support Professional staff must meet all training requirements and timeframes for training completion and as specified in the DDDS Training Policy.
- Must be certified as a Supported Employment provider by the Division of Developmental Disabilities Services by demonstrating the competencies and capacity to provide vocational services as described in Section 4.0 of this manual to individuals with intellectual disabilities.
- A Job Coach/Employment Specialist must meet the following minimum standards:
    - Successful completion of an Employment Specialist Curriculum as approved by DDDS. Completion must occur within six months of date of hire. Persons who have not completed an approved Employment Specialist curriculum and who are currently providing services as of the effective date of this standard shall have six months to come into compliance.
    - Receive mentoring during the first six months of employment. The mentor must have worked for a minimum of one year as an Employment Specialist and have completed an approved Employment Specialist Curriculum.
    - Graduation from high school or acquired a GED; Persons without a high school diploma or a GED and currently providing the services as of the effective date of this rule will have three years to obtain the minimum educational requirements.

2.3 Residential Habilitation

Residential Habilitation Services may be provided in a neighborhood group home setting, a supervised or staffed apartment (community living arrangement), or a shared living arrangement (formerly titled adult foster care).

Residential Habilitation Agency – Including Neighborhood Group Homes and Community Living Arrangement

All residential habilitation agency providers must meet the following standards:

- Must be certified as a Residential Habilitation Agency provider by the Division of Developmental Disabilities Services by demonstrating the competencies and capacity to provide residential habilitation as described in Section 4.0 of this manual to individuals with intellectual disabilities.
- Must adhere to all standards, policies, and guidelines in the DDDS Purchase of Service Contract including the DDDS HCBS Waiver Certification Standards.
- All Direct Support Professional staff must meet all training requirements and timeframes for training completion as specified in the DDDS Training Policy.
- All Direct Support Professional staff must receive a background check consistent with DDDS Qualified Provider Standards and possess a valid Driver's License if transporting consumers.

Neighborhood Group Homes

In addition to the standards above for Residential Habilitation agencies, neighborhood group homes must be licensed by the Division of Health Care Quality (DHCQ) under the regulatory standards for Neighborhood Homes for Persons with Developmental Disabilities codified at Title16, Delaware Administrative Code, Section 3310.

Shared Living Providers

Shared Living providers must meet the following standards:

- Must be certified as a Residential Habilitation provider by the Division of Developmental Disabilities Services by demonstrating the capacity to provide residential habilitation services under a Shared Living model as described in Section 4.0 of this manual to individuals with intellectual disabilities.
- Must adhere to all standards, policies, and guidelines in the DDDS Purchase of Service Contract including the DDDS HCBS Waiver Certification Standards.
- Must pass the initial home inspection performed by DDDS.
- Must receive a favorable criminal background check on the primary Shared Living Provider and any other adult (over 18) residents in the house. Criminal Background reports must be reviewed in accordance with the standards set forth by Division of Health Care Quality (DHCQ) Criminal Background Check Unit Disqualifying Crimes Conviction/Time Parameters.
- Must submit all required employment letters.
- Must submit letters of reference indicating the suitability of the primary caregiver to host a person with an intellectual developmental disability in their home.
- Must be free of Tuberculosis as determined by laboratory test results for all adult members (over 18) of the household.
- Must pass the drug screen for the applicant and all adult members of the household.
- Must receive favorable checks for all adult members of the household against the:
    - Adult Abuse Registry

- Child Protection Registry
- Sex Offender Registry (no adults in the home may be convicted and/or registered Sex Offenders).

- Must not have any serious moving violations on their driving record.
- Must successfully complete the DDDS training curriculum for Shared Living Providers.
- Must be licensed by Division of Health Care Quality if a provider of residential support to more than 1 individual at the same time.
- Must provide a copy of the current Residential Family Care license to the respective regional Shared Living Coordinator annually.

2.4 Community Transition

Community Transition Service providers must be qualified by DDDS under the provider standards for Residential Habilitation or as a provider of Community Transition Services. A provider of Community Transition services may include retail establishments that sell, directly to the public, furniture and other household items eligible for the service as defined in the Lifespan waiver.

2.5 Clinical Consultation

Behavioral Consultation

Behavioral Consultants must have education, training, and/or experience demonstrating competence in each of the following areas:

- Possession of a Bachelor's degree or higher in Behavioral or Social Science or related field. Individuals who exceed the stated minimum qualifications may also provide Behavioral Consultation.
- Six months experience in developing functional assessment plans by assessing behavioral needs and determining behavioral objectives.
- Six months experience in evaluating and assessing consumer functioning using a variety of formal tests and survey tools.
- Six months experience in making recommendations as part of a consumer's service plan such as clinical treatment, counseling, or determining eligibility for health or human services/benefits.
- Six months experience in interpreting laws, rules, regulations, standards, policies, and procedures.

In addition to the requirements above, a Behavior Consultant must adhere to DDDS standards, policies, and procedures applicable to Behavioral Services as described in the DDDS HCBS Waiver Services Behavioral Consultative Services Policy. A Behavior Consultant must also adhere to all standards, policies, and guidelines in the DDDS Purchase of Service Contract including the DDDS HCBS Waiver Certification Standards.

Nurse Consultation

- Nurse Consultants must be a Registered Nurse (RN) licensed by the State of Delaware as prescribed in Delaware Code, Title 24, Chapter 19, Section 1910.
- Nurse Consultants must demonstrate the ability to work with individuals with Intellectual Developmental Disabilities with a wide range in the intensity of support needs including cognitive impairments, autism, mobility, dual diagnosis (intellectual developmental disability & mental illness), or who have more significant health related challenges.
- Must adhere to all standards, policies, and guidelines in the DDDS Purchase of Service Contract including the DDDS HCBS Waiver Certification Standards.

Providers that are qualified to provide Residential Habilitation Service that are also qualified to provide another waiver service such as Behavior or Nursing Consultation or a Day or Vocational must respect the consumer's choice of provider of those other non-residential waiver services, which may be a different provider. Consumers must have choice among all qualified providers. If a consumer in residential care chooses a provider other than the residential provider to provide another waiver service, the residential provider must cooperate with the other providers for the benefit of the consumer. Residential providers may not prevent a consumer from receiving a waiver service from another provider. If a residential consumer transfers to another residential provider and wishes to continue to receive another waiver service from the first residential provider, that provider must not terminate the consumer for that reason.

2.6 Supported Living

Supported living may be provided by an agency that has been determined by DDDS to meet the program qualifications for residential habilitation. Because this service is provided in a residence owned or leased by the waiver member, licensing requirements that apply to Neighborhood Group Homes or Community Living Arrangements related to the residence do not apply.

2.7 Assistive Technology

Provider Type	License	Certification	Other Standard
Certified Orientation and Mobility	n/a	COMS	Meet minimum standards as set forth by Department of Vocational Rehabilitation or Division for the

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

2.8 Specialized Medical Equipment and Supplies

Must have a Delaware State Business License and must be enrolled to provide Durable Medical Equipment under the State Plan.

2.9 Family Support Services

Respite and Personal Care - Self-Directed Option:

Must have a Medicaid administrative contract with the state to perform the function of an Agency with Choice Broker for individuals receiving respite or personal care. The broker will be responsible for ensuring that all self-directed caregivers meet applicable qualifications prior to the delivery of service. The broker must comply with all applicable state and federal requirements including the U.S. Fair Labor Standards Act.

Respite and Personal Care – Agency Option:

Provider Type	License	Certification	Other Standard *(Specify):*
Home Health Agency	State Business License or 501 (c)(3) status; and State Home Health Agency License from Office of Health Facilities Licensing and Certification per Delaware Code Title 16-4406 Home Health Agencies (Licensure).	N/A	Comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. Complete and ensure employees complete Department-required training, including training on the participant's service plan and the participant's unique and/or disability-specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs. Individuals employed by providers must: • Be at least 18 years of age. • Have criminal background investigations in accordance with state requirements. • Have a screening against the child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del Code Section 708 and 11 Del Code Sections 8563 and 8564 and not have an adverse registry findings in the performance of the service.

			In the case of direct care personnel, possess certification through successful completion of training program as required by the Department.
Personal Assistance Services Agency	State Business License or 501(c) (3) status; and State Personal Assistance Services Agency License from Office of Health Facilities Licensing and Certification per Delaware Code Title 16-4469.	N/A	Comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. Complete and ensure employees complete Department-required training, including training on the participant's service plan and the participant's unique and/or disability-specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs. Individuals employed by providers must: • Be at least 18 years of age. • Have criminal background investigations in accordance with state requirements. • Have a screening against the child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del Code Section 708 and 11 Del Code Sections 8563 and 8564 and not have an adverse registry findings in the performance of the service. • In the case of direct care personnel, possess certification through successful completion of training program as required by the Department.

Respite – Shared Living Provider

Must be qualified by DDDS as meeting the qualifications for Shared Living.

Respite – Facility-based

Neighborhood Group Home or Staffed Apartment

Must be credentialed by the Division of Developmental Disabilities as a qualified provider of Residential Habilitation.

Must meet the DDDS standards for Residential Habilitation published on the DDDS website. This includes non-licensed agencies that provide Residential Habilitation in a Community Living Arrangement (i.e. staffed apartment).

Intermediate Care Facility for Individuals with Intellectual Disabilities

Must be licensed by the Delaware Division of Long Term Care Residents Protection as a nursing facility.

Must be certified by the Delaware Division of Long Term Care Residents Protection as meeting the federal qualifications of an Intermediate Care Facility for Individuals with Intellectual Disabilities.

Must be owned or operated by a government entity.

Home Modifications

Licensed contractor: Individual or agency

Must be licensed as a contractor to do business within the State of Delaware and hold all applicable certifications and standards, if required by trade, and general liability insurance. Providers must warranty their work for one year from the date of purchase.

Vehicle Modifications

Vehicle Modification Vendor - Providers must be bonded and insured. Providers must warranty their work for one year from the date of purchase.

3.0 Client Eligibility for Enrollment in the DDDS Lifespan Waiver

3.1 Waiver Eligibility Criteria

3.1.1 The DDDS Lifespan Waiver is targeted to individuals diagnosed with intellectual disabilities (including brain injury), autism spectrum disorder or Prader Willi Syndrome who require supports in order to continue to live in the community, including living with their family.

3.1.2 An individual must meet the following criteria before being enrolled in the DDDS Lifespan Waiver:

3.1.2.1 Must be determined eligible for DDDS services as delineated in the Delaware Administrative Code, Title 16, Section 2100. The criterion requires a diagnosis of an intellectual developmental disability, including brain injury, autism spectrum disorder or Prader Willi Syndrome that occurred within the developmental period and the existence of functional limitations.

3.1.2.2 Must be age 12 years or older.

3.1.2.3 Must be included in one or more of the priority groups for which capacity has been reserved, including individuals who:

- have exited from K-12 schools
- have aged out of the Pathways to Employment Program
- are returning to the community after a period of institutionalization
- have experienced the loss of a caregiver or a change in the caregiver's status that prevents them from meeting the needs of the individual and puts them at risk of homelessness.

3.1.2.4 Must require the Level of Care as provided in an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID) and as defined in the Social Security Act and enabling regulations.

3.1.2.5 Must have income less than 250% of the Federal Benefit Rate (SSI Standard Benefit for an individual). Individuals who are receiving SSI are automatically under the waiver income threshold.

3.1.2.6 Must not have resources that exceed the limit established by federal statute for individuals receiving Supplemental Security Income (SSI) benefits.

3.1.2.7 Must be able to be maintained safely in the community with the provision of waiver services in lieu of institutional services.

3.2 Waiver Enrollment

3.2.1 If the above eligibility criteria are met, then there must also be a funded waiver slot in order for an applicant to be enrolled in the DDDS Lifespan Waiver.

3.3 DDDS Lifespan Waiver Provider Responsibilities

3.3.1 The providers acknowledge, and are bound to and responsible for all terms and conditions of the signed contract with DMAP and the policies and procedures outlined in this provider specific manual.

3.3.2 The providers agree to be responsible for full, current, and detailed knowledge of published federal and state laws, regulations, and guidelines pertinent to providing services under the DDDS Lifespan Waiver and to request any necessary interpretation of specific provisions.

3.3.3 The provider is responsible for ensuring that all claims submitted for payment adhere to the minimum Medicaid requirements for documentation.

3.3.4 The providers agree to complete progress reports for services provided to each individual enrolled in the DDDS Lifespan Waiver and to make such reports available to designated DDDS representatives.

3.3.5 The providers agree to establish a system through which consumers may present grievances about the operation of the service program. The provider must advise consumers and their families or legal guardians, as appropriate, of the right to grieve the provision of Medicaid services which includes failure to recognize a consumer's choice provider or service and of their right to a Medicaid fair hearing.

3.3.6 By enrolling with DMAP to become a Medicaid waiver service provider, providers agree to provide service to any waiver member who chooses them to provide a service, unless they are at capacity or if the provider cannot or can no longer safely support a DDDS Lifespan Waiver member. If this occurs, the provider must provide a written explanation of why they cannot safely serve the member and participate in the development of a team risk mitigation plan. If the provider is already supporting the waiver member, and can no longer safely support the person, the provider must continue to provide services at the current authorized level of support while the team develops a transition plan. Providers must honor consumer choice. If the consumer expresses a desire to change providers, the provider will continue to provide services to the consumer as authorized and will

assist with the development of a transition plan until the consumer has transitioned to the new service or service provider.

3.3.7 The providers cannot refuse to provide service to a Medicaid recipient who selected them to be their service provider unless they have reached their maximum capacity for the number of individuals that can be served based on available staffing or for health and safety reasons as specified in 3.3.6 above.

3.3.8 Providers that are qualified to provide Residential Habilitation Service that are also qualified to provide another waiver service such as Behavior or Nursing Consultation or a Day or Employment Services must respect the consumer's choice of provider of those other waiver services, which may be a different provider. Consumers must have choice among all qualified providers. If a consumer in residential care chooses a provider other than the residential provider to provide another waiver service, the residential provider must cooperate with the other providers for the benefit of the consumer. Residential providers may not prevent a consumer from receiving a waiver service from another provider. If a residential consumer transfers to another residential provider and wishes to continue to receive another waiver service from the first residential provider, that provider must not terminate the consumer for that reason.

3.3.9 All waiver providers must cooperate with providers of Medicaid State Plan services such as private duty nursing, home health, and non-emergency transportation to ensure that the needs of waiver services members are met. For residential service providers, this means that they must allow a provider of Medicaid State Plan services or another waiver provider to provide such services in the waiver member's place of residence.

3.4 Client Rights

3.4.1 Waiver participants have the right to choose any qualified provider that has the capacity to provide the needed service to them. Waiver participants have the right to change providers at any time for any reason. Failure to honor consumer choice when there are no mitigating circumstances would be grounds for the consumer to file a rights complaint.

3.4.2 Waiver participants have the right to request a Medicaid Fair Hearing related to any adverse decision, including the denial of eligibility; the denial, reduction, suspension or termination of Medicaid HCBS services for an individual; or the lack of choice of a service provider.

3.4.3 If an applicant or consumer requests a fair hearing, DMAP agrees to make arrangements to provide such a hearing through its normal fair hearing procedures.

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4.0 Description of Covered Services

4.2 Day Services

Individuals receiving Day Habilitation, Community Participation or Prevocational services may also receive Supported Employment. A participant's person-centered plan may include two or more types of day and employment services; however, different types of day services may not be billed for the same part of the day.

General Performance Expectations for All Day Services:

Day Services will have performance/outcome measures stipulated for each program (i.e. QA indices). Individuals shall participate in activities or work that match their interest and abilities. Day Services shall use least restrictive alternatives that are consistent with the needs of the individual and shall operate in accordance with the principal of person-centered service delivery. Day Service program staff must record and report the progress of individuals per their person-centered plans.

Day Habilitation Services

Day Habilitation Services are provided for participants who have identified a need to maintain or increase their level of independence with Adaptive Skills, Socialization, Activities of Community Living, and/or Activities of Daily Living. Activities provided in a Day Habilitation program should lead to the following outcomes; obtaining and/or maintaining skills that build positive social behavior and interpersonal competence and to increase independence and personal choice. Although Day Habilitation activities may be provided in a location that would be considered recreational in nature, the purpose of the environment is to provide the opportunity to acquire the identified skill.

Day Habilitation Services may include assistance with gaining and/or maintaining skills in the following areas:

- Adaptive Skills that enhance social development;
  - Self-Care – dressing, grooming, and feeding one's self;
  - Communication Skills – understanding and using verbal and nonverbal language, use of communication device;
  - Self-Direction – problem solving, exercising choice, initiating and planning activities;
  - Social Skills – maintaining interpersonal relationships, understanding emotions and social cues, understanding fairness and honesty, obeying rules and laws;
  - Leisure Skills – taking responsibility for one's own activities, having the ability to participate in the community;

- Transition to Independent Living– using public transportation, using community resources, housekeeping, cooking, doing laundry, maintaining living space, shopping;
- Functional Academics – using reading, writing, and math skills in everyday life;
- Health and Safety – ability to protect one's self, responding to health problems.

- Socialization
  - Providing an individual with the skills and opportunities necessary for participating within his or her own society.
- Activities of Community Living
  - Taking medications as prescribed;
  - Managing money;
  - Shopping for groceries or clothing;
  - Use of telephone or other form of communication;
  - Using technology (as applicable);
  - Transportation within the community;
  - Communication management;
  - Community orientation;
  - Health management and maintenance;
  - Meal preparation and cleanup;
  - Safety procedures and emergency responses.
- Activities of Daily Living
  - Bowel and bladder management (recognizing the need to relieve oneself);
  - Dressing;
  - Eating (including chewing and swallowing);
  - Feeding (setting up food and bringing it to the mouth);
  - Functional mobility (moving from one place to another while performing activities);
  - Personal device care (maintenance of adaptive equipment);
  - Personal hygiene and grooming (including brushing/combing/styling hair);
  - Toilet hygiene.

Day Habilitation may not routinely provide for the payment of services that are vocational in nature (i.e., for the primary purpose of producing goods or performing services).

Personal care/assistance may be a component part of day habilitation services as necessary to meet the needs of a participant, but may not comprise the entirety of the service.

For individuals with degenerative conditions, day habilitation may include training and supports designed to maintain skills and functioning and to prevent or slow regression, rather than acquiring new skills or improving existing skills.

Participation in day habilitation services is not a pre-requisite for individual or small group supported employment services; individuals may choose to go directly into supported employment in lieu of day habilitation.

Day Habilitation service is the provision of regularly scheduled activities in a non-residential setting, separate from the participant's private residence or other residential living arrangement, such as assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that enhance social development and develop skills in performing activities of daily living and community living, physical development, basic communication, self-care skills, domestic skills, community skills and community-inclusion activities.

Day Habilitation services may also be used to provide supported retirement activities. As some people get older, they may no longer desire to work and may need supports to assist them in meaningful retirement activities in their communities. This might involve altering schedules to allow for more rest time throughout the day, support to participate in hobbies, clubs, and/or other senior related activities in their communities that provide a specific beneficial outcome to the recipient.

The individual's person-centered services and support plan must include Day Habilitation as a desired service. Their goals, services, and supports must be consistent with the services defined as Day Habilitation Services. The Day Habilitation goals, person-centered services and supports plan must be reviewed; no less than annual, more frequently as necessary or as requested by the individual. These services and supports should be designed to support successful outcomes consistent with the individual's goals.

Transportation to and from the planned service location for each day is a component part of Day Habilitation and the cost of this transportation may be included in the rate paid to providers of Day Habilitation services.

Day Habilitation – Community Participation

Community Participation services are the provision of scheduled activities outside of an individual's home that support acquisition, retention, or improvement in self-care, sensory-motor development, socialization, daily living skills, communication, community living, and social skills. Community Participation services include supervision, monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills and training and education in self-determination. Community Participation may include self-advocacy training to assist the participant in expressing personal preferences, self-representation, and individual rights and to make increasingly responsible choices. Each individual receiving Community Participation services works toward acquiring the skills to become an active member of the community. Services are furnished consistent with the participant's person-centered plan (PCP). Because Community Participation is very individualized and is heavily focused on community exploration, it can only be provided in staffing ratios of one staff to each participant or one staff to two participants.

Community Participation services focus on the continuation of the skills already learned in order to build natural supports in integrated settings. The individual is ready to interact and participate in community activities and needs the supports of staff to facilitate the relationship building between the individual and other non-disabled participants within the community activities. Ideally, the paid staff will fade or decrease their support as the natural supports become sufficient to support the individual in the integrated settings and activities.

Community Participation may be furnished in the general community, or any combination of service locations, provided that the activities take place in a non-residential setting that is separate from the participant's private residence or other residential living arrangement. Individuals may gather at the beginning and end of the day at a "hub" before embarking on their activities of the day but may not spend any more than 1 hour in total at the hub per day. Other than the brief period at the beginning or end of the day, Community Participation cannot be delivered in a provider owned or managed setting.

The provider must actively promote and be capable of providing opportunities for full access to participate in the greater community for those waiver participants that express a desire for such access and for whom it would not be contrary to their health and safety needs as articulated in their person-centered plan. The provider must demonstrate that they support individuals to exercise their option to achieve their desired level of participation in the community. To the greatest extent possible, individuals should be exposed to a broad array of community experiences so that they can make informed choices about what they like and what they don't like.

Transportation to and from the planned service location for each day is a component part of Community Participation and the cost of this transportation may be included in the rate paid to providers of Community Participation services.

Prevocational Service

Prevocational Services are learning and work experiences, including volunteer work that assist the individual to develop general, non-job-task-specific strengths and skills (soft skills) that contribute to employability related to the participant's identified employment goal. The outcome of this service is competitive, as integrated employment in the community is matched to the individual's interests, strengths, priorities, abilities, and capabilities.

Prevocational Services may include activities that assist the individual to improve their:

- Ability to communicate effectively with supervisors, co-workers, and customers;
- Ability to display generally accepted community workplace conduct and dress;

- Ability to follow directions;
- Ability to attend to tasks;
- Workplace problem solving, skills and strategies;
- General workplace safety;
- Mobility Training.

A clear distinction must be made between Prevocational Services and Vocational Services. Prevocational Services focus on teaching general skills (soft skills) that contribute to the individual's employability. Vocational Services are services that teach job task specific skills. The only vocational services covered under the DDDS Lifespan Waiver are Supported Employment - Individual and Supported Employment – Group.

The Workforce Innovation Opportunities Act (WIOA) states that individuals with disabilities aged 24 and younger would no longer be allowed to work for less than the Delaware minimum wage of $8.25 per hour, unless they first receive pre-employment transition services at school, and try vocational rehabilitation services through DVR.

Prevocational Services are expected to occur over a defined period of time with specific employment outcomes to be achieved, as determined by the individuals and his/her service and supports planning team through an ongoing person-centered planning process.

Individuals receiving Prevocational Services must have employment related goals in their person-centered services and supports plan, and the Prevocational activities must be designed to support such employment goals.

A person receiving Prevocational Services may pursue employment opportunities at any time to enter the general work force. Prevocational Services are intended to assist individuals to enter the general workforce.

Participation in Prevocational services is not a pre-requisite for individual or small group supported employment services; individuals may choose to go directly into supported employment in lieu of Prevocational services.

The individual's person-centered services and support plan must include Prevocational Services as a desired service and their goals, services and supports must be consistent with the services defined as Prevocational Services. The Prevocational goals, person-centered services, and supports plan must be reviewed no less than annually, more frequently as necessary or as requested by the individual. These services and supports should be designed to support successful employment outcomes consistent with the individual's goals.

Prevocational Services may include volunteer work, such as learning and training activities that prepare a person for entry into the paid workforce.

Individuals receiving Prevocational Services may also receive Supported Employment and/or Day Habilitation Services. A participant's person-centered services and supports plan may include two or more types of Day Services; however, different types of day services may not be billed for the same part of the day.

Personal care/assistance may be a component part of Prevocational Services as necessary to meet the needs of a participant, but may not comprise the entirety of the service.

Transportation to and from the planned service location for each day is a component part of Prevocational Services and the cost of this transportation may be included in the rate paid to providers of Prevocational Services.

4.3 Employment Services

Supported Employment - Individual

Individual Supported Employment Services are provided to participants who, because of their disabilities, need ongoing support to obtain and maintain an individual job, which is competitive or customized employment, or a self-employment position in an integrated work setting with the general workforce. The supported employment services are provided on a one-to-one staff-to-consumer ratio. Participants must be compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals in order to promote community inclusion.

Supported individual 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:

- vocational/job-related discovery or assessment,
- person-centered employment planning,
- job placement,
- job development negotiation with prospective employers,
- job analysis,
- job carving,
- training and systematic instruction,
- job coaching,

- on the job employment supports,
- social skills training, benefits support,
- training and 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 participant to be successful in integrating into the job setting.

Supported Employment - Small Group

Supported Employment Small Group Employment Support are services and training activities provided in regular business, industry, and community settings for groups of two (2) to eight (8) workers with disabilities. Examples include mobile crews and other employment work groups. Small group employment support must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces. Participants must be compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Supported employment small group employment supports may be a combination of the following services:

- vocation/job related discovery or assessment,
- person-centered employment planning,
- job placement,
- job development,
- social skills training,
- negotiation with prospective employers,
- job analysis,
- training and systematic instruction,
- job coaching,
- benefits supports,
- training and planning,
- transportation and career advancements services.

Other workplace support services may include services not specifically related to job skill training that enable the waiver participant to be successful in integrating in to the job setting.

In order for a vocational service to be covered under an HCBS waiver, documentation must be maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or IDEA (20 U.S.C. 1401 et seq.). 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 supported employment; or payments that are passed through to users of supported employment services.

4.4 Residential Habilitation

Residential services can include assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming, cleanliness, bed making, household chores, eating, preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional community-based setting. These services are individually planned and coordinated through the individual's person-centered plan (PCP). The scope of these services is based on the individual's need and can be around-the-clock or in blocks of hours.

Residential Habilitation Services may be provided in a neighborhood group home setting, a supervised or staffed apartment (community living arrangement), or a shared living arrangement (formerly titled adult foster care).

Payments for residential habilitation are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. Transportation is a component part of Residential Habilitation Services for Neighborhood Group Homes and Community Living Arrangements.

Coverage by provider agency direct care staff during consumer hospitalizations cannot be paid for under the DDDS Lifespan Waiver.

The following activities may be performed under all types of Residential Habilitation:

- Self-advocacy training that may include training to assist in expressing personal preferences, self-representation, individual rights and to make increasingly responsible choices.
- Independent living training may include personal care, household services, child and infant care (for parents themselves who are developmentally disabled), and communication skills such as using the telephone.
- Cognitive services may include training involving money management and personal finances, planning and decision making.
- Implementation and follow-up counseling, behavioral or other therapeutic interventions by residential staff, under the direction of a professional, that are aimed at increasing the overall effective functioning of an individual.
- Emergency preparedness.
- Community access and inclusion services that explore community services available to all people, natural supports available to the individual, and develop methods to access additional services/supports/activities desired by the individual.
- Supervision services may include a person safeguarding an individual with developmental disabilities and/or utilizing technology for the same purpose.

Once a consumer has selected a provider agency to provide residential habilitation services, it is the provider's responsibility to ensure that the residential sites that are recommended to the consumer must be able to meet the consumer's physical needs. This includes ensuring that facilities are accessible where necessary and that accommodations are made to address the special needs of individuals who are deaf or have visual impairment consistent with ADA requirements. After an initial site has been chosen and the consumer has moved there, any recommendation for a move to a different site for any reason must be discussed at a meeting that includes all team members, including the DDDS Support Coordinator.

Any time a waiver member receiving residential services moves from one residential location to another, a transfer planning conference must be held prior to the move to ensure that adequate measures have been put in place to ensure the member's continued safety and well-being.

Shared Living Arrangement

Services provided under a Shared Living arrangement include personal care and supportive services (e.g., homemaker, chore, attendant care, companion, medication oversight (to the extent permitted under State law) provided in a DDDS-certified private home by a principal care provider who lives in the home. A Shared Living arrangement is furnished to adults who receive these services in conjunction with residing in the home. The Division, although committed to one-person Shared Living homes, does allow for exceptions to the one-person rule. An individual (or their team on behalf of the individual) may request an exception to increase the maximum number up to 3. The exception request will be scrutinized to ensure it is consumer-driven and in the best interest of the individual already residing in the home. Exceptions to allow for up to 3 adult siblings who want to remain together or where 2 individuals are very close and want to live together are examples of exception requests that are very likely to be approved. Separate payment is not made for homemaker or chore services furnished to a participant receiving shared living arrangement services, since these services are integral to and inherent in the provision of shared living arrangement services.

Shared Living providers must provide or arrange for transportation to all activities and services as required by the individual unless transportation is provided as a part of another waiver service. Medicaid recipients in a Shared Living arrangement can access transportation to and from medical appointments via the Medicaid Transportation Broker.

4.5 Clinical Consultation

Behavioral Consultation

Behavioral Consultation is provided under the Positive Behavior Support model. Behavioral Consultation results in individually designed behavior plans and strategies for waiver participants who have significant behavioral difficulties that jeopardize their ability to remain in the community due to their inappropriate

responses to events in their environment. The behavioral consultation is designed to:

1) decrease challenging behaviors while increasing positive alternative behaviors, and

2) assist participants in acquiring and maintaining the skills necessary to live independently in their communities and avoid institutional placement.

The Behavioral Consultation Service includes a functional assessment, development of a behavior support plan, and implementation of the Behavioral Support Plan to enable individuals, families, and service providers to effectively support the waiver member in their attainment of the goals they have set. The Behavioral Consultation providers use a standardized functional assessment to determine the needs of each individual. The service includes periodic monitoring of the effectiveness of the Behavioral Support Plan with requisite adjustments as indicated.

The Behavioral Consultation Service shall include the development of behavioral strategies, as allowed within the scope of practice of the Behavior Consultant, and when clinically indicated and if desired by the waiver member and their family.

The Behavioral Consultation Service may include the development of a Picture Communication System, visual schedule and/or social story for waiver participants who experience communication challenges.

Specifically, Behavioral Consultation includes:

- Completing the Functional Assessment of Behavior, as needed, to better understand the function, triggers/antecedents and variables predictive of occurrence/non-occurrence of target behaviors.
- Providing consultation, training and direction to waiver member's support team and other direct support professionals who work with the waiver member who displays challenging, maladaptive or self-limiting behaviors.
- Developing Behavior Support Plans incorporating the principles of Positive Behavior Supports in order to reduce maladaptive or self-limiting behavior and increase appropriate positive behaviors. This may include the creation of a Picture Communication System, visual schedule and/or social story.
- Instructing support teams, direct support professionals and family members and others with whom the waiver member routinely interacts on the principles of Positive Behavior Support and implementation of the behavioral support plan. This may include training on a Picture Communication System, visual schedule and/or social story.
- Monitoring the outcome of the behavioral support plan through data collection and observation associated with the implementation of the Behavior Support Plan.
- Maintaining the waiver member's record which may include the following:
    - Documentation of progress/treatment for people who have Behavior Support Plans on at least a monthly basis;

- The creation of a quarterly report that identifies target behaviors for which data will be collected for specific types of incidents and also delineates psychiatric appointments, medication training, staff training, mental health appointments, medical issues and at risk concerns that occurred during the quarter.

- Obtain consent from the individual, guardian, power of attorney, surrogate decision maker, or other alternative decision maker as appropriate.
- Read incident reports and daily staff notes, and respond timely and appropriately as necessary.
- Notify Support Coordinator when the individual presents issues and concerns.
- Advocates for the individual if he/she feels there may be alternative treatment or the individual has increased needs.
- Attend annual Lifespan Plan meetings, emergency meetings, transfer planning meetings, facility discharge meetings, and psychiatric appointments.

In cases where psychological or professional counseling or assessment services are indicated, upon request of the waiver member, the BA will:

- Identify potential mental health practitioners;
- Act as a liaison between the individual, his/her support team and the service provider to ensure that the mental health practitioner receives information necessary to appropriately treat the person;

In cases where psychiatric services are needed, upon request of the waiver member, the role of the BA is to:

- Identify potential mental health practitioners;
- Act as a liaison between the individual, his/her support team and the service provider to ensure that the mental health practitioner receives information necessary to appropriately treat the person;
- Ensure PAIR is completed by the prescriber and attaches a copy to the electronic record
- Instruct the team on how to carry out the prescribed treatment;
- Develops Mental Health Support plans to ensure that the individual is supported in accordance with the principles of best practice;
- Monitors progress/treatment for people who have Behavior Support Plans;
- Serves as a support team participant for people who have a behavior support plan.
- Prepares and presents necessary documentation for oversight committees such as PROBIS and HRC in accordance with DDDS policies.

Nursing Consultation

Nursing Consultation consists of the overall coordination and monitoring of the health care needs for waiver participants. These individuals live in community settings and have a prescribed medical treatment plan. This consultation assists caregivers in carrying out individual treatment/support plans and is necessary to improve the individual's independence and inclusion in their community. This service may be delivered in the individual's home or in the community as described in the service plan.

Nursing Consultation consists of the following activities:

- Provides the clinical and technical guidance necessary to support the individual in managing his/her healthcare needs.
- Completes the Nursing Assessment, develops an integrated Plan of Care and monitors the effectiveness of the interventions on no less frequent than an annual basis.
- Completes the DDDS Medical Alert forms, Fall Risk Assessment, Aspiration Assessment, and any other assessments as appropriate on no less frequent than an annual basis.
- Completes on-site medication/record reviews for Neighborhood Homes and Community Living Arrangements (e.g. the monthly Health and Medication Review as outlined in all applicable DDDS policies and procedures). Findings of all reviews must be reported to DDDS and the appropriate agency staff for corrective action.
- Notify Support Coordinator when individual presents issues and concerns.
- Completes monthly contacts (phone/in person) and at least an annual on-site visit for Shared Living Providers. During the on-site visit, the nurse will verify that medication storage follows the DDDS guidelines.
- Completes Quarterly Nursing Reviews for individuals residing with Shared Living Providers.
- Monitors, reviews, and reconciles medication forms monthly and takes appropriate action as indicated for individuals residing with Shared Living Providers.
- In emergency situations, may perform a medical procedure within the registered nurse's scope of practice, experience and proficiency.
- Participates as an Interdisciplinary Team member.
- Attends the annual Lifespan Plan meetings, Transfer Planning Conference meetings, and other meetings as appropriate.
- Reconcile, count and transfer medication prior to or at the time of an individual transferring from one site to another of if there is an emergency placement.
- Determines need for referral to Registered Dietician.
- Ensures baseline assessments are scheduled (OT/PT, Speech, Audiology, GYN, etc.) as needed.

- Provides ongoing health related training for individuals, staff, and families.
- Maintains on-going accurate, timely, and relevant documentation of all health care issues. Updates all required documents as changes in health conditions warrant.
- Communicates to individuals/families/guardians/other service providers about health care issues. Attends medical appointments with the individual if indicated/warranted.
- Assists in obtaining resources and acts as an advocate and coordinator of health care services ensuring appropriate treatment, follow-up, and resolution to healthcare issues occurrences.
- Assists waiver members to transition from one residential living arrangement to another.
- Adheres to DDDS healthcare protocols.
- Monitors medication administration activities performed by direct care staff or consumers.

Nursing Consultation for Shared Living Providers

- Completes a quarterly review for each person living in a Shared Living home.
- Visits Shared Living provider home at least once per year to verify medication(s) is/are kept in a secure location and that the individual's medications are not mixed with medications of other household members.
- Appends medical paperwork (Monthly Medication and Reconciliation and Tube Feeding Record, MAIR, PAIR, DAIR, Physicians electronic printout, etc.) to the electronic record once received from the Shared Living provider monthly.
- Completes an incident report/note in the electronic record if the Shared Living provider reports any issues.
- Inputs information obtained from medical paperwork such as weight, blood pressure, glucose, height, allergies, medications, etc. into the electronic record when documentation is received from the Shared Living provider monthly.
- Provides medical forms to the Shared Living provider (MAIR, PAIR, DAIR, Physical form, Over the Counter form, Monthly Medication Reconciliation form, etc.
- Monitors, reviews, and reconciles Shared Living Monthly Medication forms, and takes appropriate action as indicated.
- Adheres to DDDS, State and Federal policies and regulations.
- Ensures all new policies, procedures are read and signed within established time frame.
- Promotes functional independence of individuals during medication administration activities.
- Ensures documentation is accurate, timely, relevant, and complete.

Nurse Consultant protocols can be found in the DDDS Nurse Consultant Resource Guide on the DDDS website.

4.6 Assistive Technology

Assistive technology means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes--

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

(B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;

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

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

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

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

This applies to Assistive Technology that is not otherwise covered by Medicaid. EPSDT for individuals under age 21 and other State Plan services, such as the Home Health benefit must be accessed before this waiver benefit can be accessed. To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

Participants may only receive Assistive Technology if it has been determined to be medically necessary by a competent health professional including, OT, PT, Speech Pathologist, audiologist, or certified AT specialist. Participants must explore off the shelf products before DDDS will approve the purchase of any specialized medical equipment. Participants are limited to the lowest cost option that will meet the person's needs, including refurbished equipment, but also take into account the timeliness of delivery to meet an immediate need and the availability of warranties.

Limits: Purchase of equipment is limited to $500, including maintenance; with exceptions considered for cases of exceptional need. The limit for Assistive Technology was based on available state funds.

4.7 Home and Vehicle Accessibility Adaptations

Home Modifications

Home modifications include those physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Modifications must comply with applicable building codes and must have building permits where required.

Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Vehicle Adaptations

Vehicle adaptations are specified by the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. They include adaptations or alterations to an automobile or van that is one of the waiver participant's primary means of transportation in order to accommodate the special needs of the participant.

The following items are specifically excluded:

1. Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual;

2. Purchase or lease of a vehicle; and

3. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

Home and Vehicle Modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

4.8 Supported Living

Supported living is support that is very individualized and is provided in a non-provider-managed residence that is owned or leased by the waiver participant. The amount and type of supports provided are dependent upon what the individual needs to live successfully in the community and must be described in their person-centered plan (PCP) but cannot exceed 40 hours per week for each member. Daily hours of support may vary based on the needs of the individual. Supported living encourages maximum physical integration into the community and is designed to assist the individual in reaching his or her life goals in a community setting.

The types of supports provided in these settings are tailored supports that provide assistance with acquisition, retention, or improvement in skills related but not limited to:

- activities of daily living, such as personal grooming and cleanliness, domestic chores, or meal preparation, including planning, shopping, cooking, and storage activities;
- social and adaptive skills necessary for participating in community life, such as building and maintaining interpersonal relationships, including a Circle of Support;
- locating and scheduling appropriate medical services;
- instrumental activities of daily living such as learning how to maintain a bank account, conducting banking transactions, managing personal finances in general;
- learning how to use mass transportation;
- learning how to select a housemate;
- how to acquire and care for a pet;
- learning how to shop.

The individual may want to learn a new skill or may have some proficiency in certain parts of a skill but want to learn how to complete the entire task independently. Supported Living includes self-advocacy training to assist the participant in expressing personal preferences, self-representation, and individual rights and to make increasingly responsible choices.

Supported living must be provided based on the individualized needs of each waiver member and at naturally occurring times for the activity, such as banking and those related to personal care.

Supported living is provided on a one-on-one basis. If services are provided with two or more individuals present, the amount of time billed must be prorated based on the number of consumers receiving the service. Payments for Supported Living do not include room and board.

The maximum number of hours of support that can be provided to each individual is 40 hours per week.

4.9 Respite

Respite Services may be provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Federal financial participation is not to be charged for the cost of room and board except when provided as part of respite care furnished in a public ICF-IID facility.

Respite may be delivered in the participant's residence (family home, own home or apartment) or in community settings and may not supplant other Waiver or state plan covered services.

Facility-based respite includes services provided to participants unable to care for themselves and is furnished on a short-term basis because of the absence of relief of those persons who would normally support the participant.

Facility respite may be planned or may be used for individuals who are experiencing a short-term crisis. Facility respite may be provided on the same day that an individual also receives a day service. However, payment will not be made for respite provided at the same time when other services that include care and supervision are provided.

Facility-based respite can be provided in the following settings: Medicaid-certified public ICF-IID, Licensed Neighborhood Group Home, DDDS-credentialed Community Living Arrangement, shared living arrangement or other emergency temporary living arrangement that meets DDDS standards.

Respite is not available to individuals receiving Residential Habilitation in a Neighborhood Group Home or Community Living Arrangement.

For respite that is provided in a licensed Group Home, Community Living Arrangement, or shared living arrangement, the state will ensure that the needs and best interest of the other residents in the home are considered and they agree to the proposed arrangement before authorizing the setting for the purpose of a respite service.

Respite includes a self-directed option that will be managed by a broker under the Agency With Choice model. The AWC broker will be funded as a Medicaid

administrative activity. The AWC Broker will also process payments for participants who elect to receive respite at a respite camp.

Limits: The total payment for Respite and Personal Care services, combined, is limited to $2,700 per waiver participant per waiver demonstration year. Respite cannot be provided to waiver participants who receive residential habilitation in a provider-managed setting. If a waiver participant enrolled for less than an entire demonstration year, the annual limit will be prorated by the number of months remaining in the demonstration year.

Respite and Personal Care provided in a public ICF-IID is limited to 15 days in a 365 day period.

Exceptions to the funding limit may be granted by DDDS authorized personnel with documented justification related to the health and safety needs of the participant.

4.10 Personal Care

A range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (performing a task for the person) or cuing to prompt the participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis. Health-related services that are provided may include skilled or nursing care and medication administration to the extent permitted by State law.

Personal care includes the provision of a range of services for participants who require assistance to meet their daily living needs, ensure adequate functioning in their home and permit safe access to the community. Personal care can be provided in the participant's residence (family home, own home or apartment), with or without family caregivers present, or in community settings and may not supplant other Waiver or state plan covered services (i.e., Day Habilitation, Prevocational Service, Supported Employment or Supported Living).

Personal care can include assistance, support and/or training in activities such as meal preparation; laundry; routine household care and maintenance; activities of daily living such as bathing, eating, dressing, personal hygiene; shopping and money management; reminding/observing/monitoring of medications; supervision; socialization and relationship building; transportation; leisure choice and participation in regular community activities; attendance at medical appointments.

Personal care does not include the cost associated with room and board.

Personal care cannot be provided to individuals who are receiving residential habilitation in a provider-managed setting.

Personal Care includes a self-directed option that will be managed by a broker under the Agency With Choice model. The AWC broker will be funded as a Medicaid administrative activity.

Limits: The total expense for Personal Care and Respite services, combined, is limited to $2,700 per waiver participant per waiver demonstration year. Personal care cannot be provided to waiver participants who receive residential habilitation in a provider-managed setting. If a waiver participant enrolled for less than an entire demonstration year, the annual limit will be prorated by the number of months remaining in the demonstration year.

Exceptions to the funding limit may be granted by DDDS authorized personnel with documented justification related to the health and safety needs of the participant.

To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

4.11 Specialized Medical Equipment and Supplies not otherwise covered by Medicaid

Specialized medical equipment and supplies include: (a) devices, controls, or appliances, specified in the person-centered plan, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the State plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

Specialized Medical Equipment and Services not otherwise covered by Medicaid is only provided to individuals age 21 and over. All medically necessary Specialized Medical Equipment and Services for children under age 21 are

covered in the State plan pursuant to the EPSDT benefit. To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

4.12 Community Transition

Payments may be made for Community Transition to facilitate transition from an institution to a community setting, consistent with SMDL 02-008, or to otherwise establish a community residence for a waiver participant who has been newly approved for residential habilitation or supported living and is moving from the family home. Community Transition will enable individuals whose means are limited to furnish and decorate his or her bedroom in a manner of his or her choosing consistent with the HCBS Rule and to foster independence. Community Transition includes the reasonable, documented cost of one-time expenses and services necessary to occupy a domicile in the community, including:

- Essential furnishings, including: Bed frame, mattress and box spring or futon, dresser, wardrobe, chair, trash can, lamps, desk, small table/nightstand, bookcase, linens and pillows, window covering, wall decorations, mirrors
- Bath mats & shower curtain, grab bars and other free-standing implements to increase stability in the bathroom
- Small appliances including blow dryer, vacuum cleaner, coffee maker, toaster
- Toiletries
- Kitchen items, including: hand towels, dishes, drinkware, flatware & utensils, knives, cookware, bowls and food storage
- Initial stocking of refrigerator and pantry
- Initial supply of cleaning supplies and laundry
- Initial supply of bathroom supplies
- Clothing
- Moving expenses
- Security deposits
- Set-up fees and deposits for utility access (telephone, electric, utility, cable)
- Pest eradication
- Cleaning service prior to occupancy
- Trial visits to waiver residential settings
- Lock and key

Community transition services shall not include monthly rental or mortgage expenses, food (other than initial purchases to stock a kitchen), regular utility

charges, and/or household appliances or items that are intended for purely recreational purposes such as televisions or DVD players. Community transition expenses must include in the individual's person-centered plan and must be approved by DDDS in advance. If an individual for whom waiver funds have been used for community transition expenses moves from one waiver-funded residential setting to another, they will be able to take any such furnishings with them to their new residence if they so choose.

Total Community Transition services are limited to $4,000 per participant for 10 years. A unit of service is one transition.

4.13 Transportation - Covered only as a component part of DDDS services as noted below

Transportation to and from DDDS services and transportation within the program day may be provided as a component part of all of the DDDS services except for Supported Employment and Clinical Consultation. Transportation may not comprise the entirety of the service. Transportation (State definition) is a service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.

Transportation under the DDDS Lifespan Waiver is provided in addition to medical transportation required under 42 CFR 431.53 and transportation services under the Medicaid State plan, defined at 42 CFR 440.170(a) (if applicable).

Providers that offer transportation must ensure that only appropriately licensed drivers and responsible persons shall operate motor vehicles transporting consumers.

The transportation add-on may only be billed for days when transportation is actually provided.

4.14 State Plan Medicaid Coverage for Waiver Members

Consumers enrolled in the DDDS Lifespan Waiver are also eligible for all services normally covered by Medicaid under the Title XIX State Plan.

4.15 Case Management

Overlaying the provision of direct support to DDDS Lifespan Waiver members is case management. Case management is available for all waiver members. Case managers develop the person-centered plan and assist waiver members to choose among a set of qualified providers and facilitate their access to waiver and other paid and unpaid services and supports. They also coordinate and monitor the provision of all services identified in the person-centered plan, including waiver and other Medicaid State Plan services.

The case manager assists waiver members in accessing needed medical, social, educational and other publicly-funded services (regardless of funding source) and informal community supports needed.

Case management includes of the following set of activities:

- Development of the person-centered plan;
- Arranging for the provision of services;
- Facilitating the annual level of care redetermination and review of the person-centered plan;
- Ensuring that the individual service plans developed by providers are consistent with the goals expressed in the person-centered plan;
- Monitoring the provision of waiver services and participant satisfaction with their services;
- Assisting clients to access and manage their personal spending accounts;
- Service coordination;
- Facilitating crisis intervention;
- Referral to other needed resources including other services covered by Medicaid.

The Employment First Act of 2012 declares that “People with disabilities have a right to the opportunity for competitive employment. In order to achieve meaningful and competitive employment for persons with disabilities, employment opportunities in fully integrated work settings shall be the first and priority option explored in the service planning for working age persons with disabilities.”

The case manager must document:

- the right to the opportunity for competitive employment in the community was fully explained during the service planning process;
- the various employment services were fully explained during the service planning process;

- the individual was assisted in making an informed decision about whether or not to pursue employment during the service planning process;
- all consumers expressing an interest in employment are referred to the Division of Vocational Rehabilitation to be assessed for eligibility.

Case management delivered to waiver members is NOT a waiver service but is funded under the authority of Targeted Case Management under the Delaware Medicaid State Plan.

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5.0 Provider Reimbursement and Billing

5.1 General Information

The DMAP reimburses DDDS providers for Lifespan Waiver services in accordance with reimbursement methodologies outlined in the federally approved DDDS Home and Community-Based Lifespan Waiver. The most current version of the DDDS Lifespan Waiver can be found on the DDDS website.

5.2 Person-Centered Plan

Before Federal Funds Participation (FFP) can be used to pay for waiver services, there must be a written person-centered plan in place as required by 42 CFR Subpart G. States are allowed to establish an “initial interim plan” for new waiver enrollees that can be in place for up to 60 days while the full plan is being developed. The terms "plan of care", "person-centered plan" may be used interchangeably. The plan describes the waiver services that the waiver member has chosen to receive and the amount, frequency and duration that they have been recommended to receive of each service. DDDS will ensure that each provider that delivers services to a waiver member has access to the person-centered plan.

5.3 Inventory for Client and Agency Planning (ICAP)

The Delaware Division of Developmental Disabilities Services (DDDS) uses an adaptive assessment instrument, the Inventory for Client and Agency Planning (ICAP), to identify the direct care support needs of each individual receiving service. This information is used to determine the level of service needs and is translated into a number of hours of direct care support needed by the individual.

The rate that is paid for each hour of direct support, as determined by the methodologies described above, is independent of the ICAP assessment process. For services that are paid as a per diem, the number of direct support hours (as determined by the ICAP assessment) are multiplied by the hourly rate for direct support, producing the daily payment rate. The ICAP assessment is redone every five years or when there is a significant change in a consumer’s circumstances that would likely affect his or her support needs.

Exceptions to the ICAP

It is acknowledged that the ICAP assessment does not always adequately address support needs related to behavioral or medical issues. Therefore, DDDS may approve exceptions to the number of support hours indicated by the ICAP assessment in order to address issues such as medical or behavioral

challenges. Exceptions will be periodically reviewed to ensure that the conditions that initially indicated that an exception was necessary still exist.

5.4 Provider Reimbursement Methodologies

5.4.1 Direct Support Professional Rates for Residential Habilitation, Day Habilitation, Day Habilitation – Community Participation (non-state operated), Prevocational Service and Supported Living

DDDS is responsible for the development of statewide rates for waiver services through an MOU with DMMA, Delaware's Medicaid agency. DMMA is responsible for the final review and approval of all rates and for ensuring that rates are computed consistent with the approved methodology.

Rates for most Lifespan waiver services are based on a "market basket" methodology established in 2004. This includes residential habilitation, day habilitation, prevocational services, supported employment individual and group supported living, clinical consultation: behavioral, nurse (added to the methodology in 2012) and community participation, newly added under this amendment.

The last rebasing study for Direct Support Professional (DSP) rates was conducted in CY2013 at the direction of the Delaware General Assembly; results were published in January 2014. All DDDS HCBS providers completed a wage and cost survey in CY 2013 and interviews were conducted with a representative cross sections of 13 of the providers to validate the survey data, revisit assumptions and make sure nothing was missed in the survey.

The revisions to the composition of the market basket, the assumptions and the resulting rates were shared in draft with the provider agencies, advocates and other key stakeholders. Feedback was incorporated into the design and final rates. The Delaware provider association representing most of the DDDS waiver providers endorsed this approach. The report produced a set of recommended "Benchmark rates" for each service.

The methodology begins with the selection of a wage for each type of DSP. Wage data was obtained from the U.S. Department of Labor – Bureau of Labor Statistics and job postings from national internet employment sites for job classifications with similar requirements and duties.

In additional to the wage, the market basket methodology adds the following components, as appropriate to each service:

- Employment related expenses (%)
- Program indirect expenses (%)
- Administrative expenses (%)

Employment Related Expenses include benefits paid to or for workers above salary and wages. They include expenses such as health insurance, workers comp, unemployment compensation, state/federal payroll taxes, criminal background checks and training.

Program Related Expenses support the delivery of the service but are either non-salary expenses or are a step removed from the direct delivery of the service. These include program management, rent, utilities, program supplies, technology expenses (phones, laptops, network, and software licenses), vehicle costs for staff, quality assurance, staff recruitment costs, DSP staff time spent in allowable but not billable activities.

General and Administrative Expenses include functions that are necessary for the operation of the organization but cannot be directly related to a good or service produced by the organization. This includes: payroll and accounting, legal counsel, outside audit fees, general liability insurance, managerial salaries, corporate overhead, rent, utilities, office equipment and subscriptions.

These costs are either converted to percentages that are multiplied by the direct support hourly wage rate as a set of recursive percentages in order to develop an hourly provider DSP benchmark rate for each service or were added as individual cost factors, or a combination of both, depending on the service.

The formula to compute the hourly rate for each service using the rate components (expressed as percentage) is as follows:

(DSP wage+(DSP*(1+ERE))/(1-PI)/(1-GA))

Transportation to and from the service setting is a component part of the service for residential habilitation, day habilitation and prevocational service and is paid as an add-on to the direct support unit cost rate. Rates for residential services do not include any costs associated with room and board.

The DSP rates are periodically re-based using cost data from the most current period available. Each year, the Epilogue of the Budget Act enacted by the Delaware General Assembly indicates that DDDS “may rebase, once every one to three years” its Direct Support Professional rates. A date has not been set for the next rate rebase study. DDDS waiver rates are published on the DDDS website each year.

While all rates are initially computed as hourly rates, they may be billed as 15 minute, hourly or per diem rates. Per diem rates are computed by multiplying the hourly rate for the service by the number of hours of support needed per day. The 15 minute unit rates are computed by dividing the computed hourly rate by four.

5.4.2 For individuals receiving day habilitation, day habilitation – community participation or prevocational service, and residential habilitation, the number of DSP hours authorized per day is determined through the use of a matrix which translates the Broad Independence and General Maladaptive scores from the ICAP assessment into the number of hour of support needed per day. For participants who elect to receive more than one day service in a single day, the provider(s) must bill using 15 minute units and may not bill a per diem rate. A different methodology, described below, is used for the state-operated Day Habilitation program.

5.4.3 For residential habilitation, transportation is applied as an add-on to the DSP per diem rate. Residential habilitation rates do not include any costs associated with room and board.

5.4.4 Day habilitation and prevocational service providers may receive an add-on payment to the direct support rate if they: 1) provide or pay for transportation to and from the program or; 2) meet the requirements for the facility-based add on.

Community Participation service 1:2 staff ratio: Community Participation may be provided to no more than two individuals supported by a single staff person. The base hourly rate for Community Participation is computed assuming a 1:1 staff to consumer ratio. A separate rate must be computed when a single DSP supports two waiver members in the community. Before the base rate is divided by the number of members in the group, a gross up factor is applied to the base rate for Community Participation. This is to ensure that overhead costs are properly captured, based on the assumption that simply dividing the base rate by the 2 individuals supported by a single DSP would not adequately capture an agency's incremental costs in delivering the service. The base unit cost rate is then divided by 2.

5.4.5 **Employment Related Services**

5.4.5.1 Supported Employment - Individual

Rates for "Supported Employment - Individual" have been calculated using actual cost data as reported by providers of Supported Employment Services. Total Medicaid allowable costs for each provider were tabulated and divided by total direct care staff (job coaches, employment specialists) hours worked. This provided a cost per hour for each provider based on direct care staff hours. The average cost per hour across all agencies was used to compute an hourly rate, which is expressed as a 15 minute billable unit by dividing the hourly rate by four. Units of time 1- 7 minutes shall not be billed. Units of time 8-15 minutes shall be billed as one 15 minute unit.

5.4.5.2 Supported Employment - Small Group

The rate for Supported Employment - Small Group uses the rate for Supported Employment - Individual described above as the initial data input. The unit cost rate for Supported Employment – Individual assumes a 1:1 ratio. In order to translate the Individual rate into group rates that are dependent on the number of people in the group, the Individual payment rate must be divided by the number of participants in the group (up to a maximum of 8). A gross up factor is then applied to account for additional incremental costs related to the provision of group supported employment that may not have been captured in the base rate for Supported Employment - Individual. Supported Employment - Small Group will be paid in 15 minute billable units.

5.4.6 Behavioral Consultation

A market basket methodology, similar to that used to compute the Direct Support Professional rates is also used to compute a unit cost rate for the Clinical Consultation services, with the following differences:

- The midpoint of the salary range for the State of Delaware merit classification of Senior Behavior Analyst is used as the basis of the computation of an hourly clinician wage and the Employment Related Expenses is computed using the Delaware State Employee fringe benefit package.

- The authorized number of hours of Clinical Consultation: Behavioral is determined by a behavioral assessment performed for each waiver recipient by the state using a standardized instrument.

5.4.7 Nurse Consultation

A market basket methodology, similar to that used to compute the Direct Support Professional rates is also used to compute a unit cost rate for the Clinical Consultation services, with the following differences:

National average hourly wage data is obtained from the Bureau of Labor Statistics, Occupational Employment Statistics survey of the US DOL for the Registered Nurse job classification SOC code 29-1111 (Registered Nurse) in the industry code NAICS 623210 Residential MR Facilities. A fringe benefit factor is added to the hourly wage based on the Delaware State Employee fringe benefit package. A factor of 12% is added to the computed hourly wage that includes other employment costs to account for other direct non-salary costs such as training, supervision and travel. A separate factor of 12% is added on top of the computed hourly wage to account for administrative costs necessary to support the direct service. A 15 minute billable unit is computed by dividing the resulting hourly wage by four.

5.4.8 Community Transition

The approved provider of will submit an invoice with applicable receipts to DDDS for reimbursement. Invoices must be approved by DDDS before payment is made.

5.4.9 Assistive Technology

Assistive Technology Assessment and Training: The fee development methodology and fee schedule rates were initially produced in 2014 as part of the Pathways to Employment SPA (see pg 29 Att 3.1.1 Pathways SPA). The rate is composed of provider cost modeling using information from independent data sources such as Delaware provider compensation studies, cost data, and fees from similar State Medicaid programs. The following list outlines the major allowable components to be used in fee development.

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

They were developed as the total hourly provider costs, adjusted for productivity, and converted to the applicable unit of service.

Assistive Technology equipment is limited to $500, including maintenance. Exceptions may be considered for cases of exceptional need.

5.4.10 Specialized Medical Equipment and Supplies

Specialized Medical Equipment, not otherwise covered under the State Plan, Assistive Technology equipment and Home or Vehicle Modifications: Bids or estimates of cost for a job, equipment, or supplies are obtained from at least two vendors the individual chooses or is assisted to choose. The lowest and best price will be authorized by DDDS if the price is reasonable based on the purchase experience of the DDDS or DMMA for similar jobs, equipment or supplies and up to the maximum allowed for the service, as described in Appendix C. Bids or estimates must be obtained from at least two vendors so that DDDS can select the most reasonable bid based on the work to be performed which may take into account such elements as the time necessary to perform the work. In the event that the time necessary to obtain two bids will result in a delay in receiving the service that could pose a health or safety risk to the participant, DDDS may waive this requirement but will use internet resources, within the time available, to identify a reasonable cost for the same or similar products and services.

5.4.11 Respite and Personal Care

For members using the Agency With Choice (AWC) self-directed model, payment rates will be established by AWC broker as the employer of record with input from the waiver member. The AWC provider will ensure that all rates and payments comply with the US DOL Fair Labor Standards Act, including the payment of overtime and travel between worksites, when appropriate. The AWC provider may reimburse for camps and institutions that provide respite at the usual and customary fee for those entities. For members who choose to use a Home Health Agency or Personal Attendant Services Agency (PASA), respite and personal care will be paid using the rates computed as follows. The rate for respite or personal care provided by a Home Health Agency will be set at the rate established under Attachment 4.19-B of the Delaware State Plan for Medical Assistance, page 6 for a HH Aide. This methodology and rate was approved by CMS effective 10/1/15. For respite or personal care provided by PASA, the rate will be 75% of the State Plan Medicaid rate for Home Health Agencies for an aide. This percentage was derived by comparing usual and customary hourly rates for aide services delivered through Home Health Agencies as opposed to PASA agencies and establishing the relationship between the rates. PASA agencies have a lower overhead because they do not have to comply with the stringent Medicare requirements with which Home Health Agencies must comply. Payment for respite provided in a DDDS waiver residential facility will be made at the residential habilitation rate. Payment for respite in an ICF-IID rate will be made using the payment methodology described in Attachment 4.19-D of the State Plan.

5.4.12 Home or Vehicle Modifications

Bids or estimates must be obtained from at least two vendors so that DDDS can select the most reasonable bid based on the work to be performed which may take into account such elements as the time necessary to perform the work. In the event that the time necessary to obtain two bids will result in a delay in receiving the service that could pose a health or safety risk to the participant, DDDS may waive this requirement. Providers must issue a warranty for their work for one year from the date of purchase.

5.4.13 The State of Delaware periodically reviews the rate setting models to determine whether it still accurately reflects the items in the market basket and the costs of those items in relation to the direct support professional wage in the applicable service market and is sufficient to ensure adequate access to services for waiver members. Rates for DDDS Lifespan Waiver services may be increased from time to time as funds are appropriated by the Delaware General Assembly.

Waiver rates are computed by DDDS and approved by DMMA. Approved rates are published on the DDDS website at the following address:

http://dhss.delaware.gov/dhss/ddds/waiver_rates.html

5.5 Provider Billing General Information

Medicaid Program Integrity: Submitting claims for units of service in excess of the number of direct support units actually provided or authorized would be considered an overpayment by DMAP, CMS or other federal auditing body. Such claims are subject to recoupment. If DMAP or the federal entity determines that the overbilling was purposeful, the Office of Inspector General of the U.S. DHHS has the authority to sanction the provider by excluding it from participation in the Medicaid and Medicare programs for a period of 5 years (see regulatory citation below).

§1003.102 Basis for civil money penalties and assessments.

(a) The OIG may impose a penalty and assessment against any person whom it determines in accordance with this part has knowingly presented, or caused to be presented, a claim which is for…..

(1) An item or service that the person knew, or should have known, was not provided as claimed, including a claim that is part of a pattern of practice of claims based on codes that the persons knows or should know will result in greater payment to the person than the code applicable to the item or service actually provided.

Service Documentation: Records must be maintained in one or more documents, to document the provision of service to an individual, consistent with the individual's person-centered plan. The provider assumes responsibility for ensuring that documentation complies with standards at the time of submitting the claim to DMAP or invoice to DDDS. At least one billable note must be maintained for each service delivered for each service day. Documentation must be located in an approved electronic software program and must be kept in a manner as to fully disclose the nature and extent of services delivered which include, at a minimum:

- Type of Service;
- Date of Service;
- Place of Service;
- Name of Individual receiving service;
- Description of activities and supports performed by staff on the service date and any response by the service recipient to the staff supports;
- Documentation of the activities and supports within the individualized service plan (ISP) developed by the provider in support of the person-centered plan that is consistent with the type of service that is authorized;
- Medicaid ID number of the individual receiving service;
- Name of Provider;

- Signature (may be electronic) or initials of the person delivering the service (if signature and corresponding initials are on file with the provider).

In accordance with the Medicaid state manual, 2500.2, Section A, supporting documentation must be available at the time the claim is submitted.

Providers of DDDS Medicaid covered services must maintain the records necessary and in such form to disclose fully the extent of the service provided, for a period of six years from the date of receipt of payment or until an initiated audit is resolved, whichever is longer. The records will be made available upon request. The DDDS may audit provider records, including any source documentation supporting Medicaid claims for DDDS Lifespan Waiver or State Plan Rehabilitative services. The provider agrees to fully cooperate with DDDS during such inquiry.

Claim Timeliness Standard: It is a federal requirement that claims to DMAP must be submitted no later than twelve months from the date of service (see DMAP General Policy Manual section 1.19.1). Therefore, claims for payment of HCBS Waiver and State Plan Rehabilitative Services must be submitted to DMAP no later than one year from the end of the month in which service was provided.

Billable Unit: A billable unit is defined as the smallest unit of time a provider is authorized to bill a Medicaid Home and Community-Based Service provided by a direct care staff employed by a qualified Medicaid HCBS provider. For services that are authorized to be billed in units of a day, DDDS will provide the provider with the number of ICAP hours on which the per diem rate was based, so that the providers know what DDDS's expectation is regarding the number of hours of direct support that is expected to be provided each day on average. It is incumbent on the provider to ensure that qualified direct care staff is scheduled and present to provide direct support as specified by the number of ICAP hours or exception hours.

During the course of a typical day of providing services to DDDS consumers, direct care staff performs a range of duties. These duties include assisting people with activities of daily living, training in skills acquisition and behavior support, maintaining health and wellness, keeping people safe and free from harm, finding and maintaining jobs, and participating in community and family inclusion. To conduct these duties, direct care staff provide hands-on support during the day as well as monitoring during the night.

In addition to documentation of the provision of service through progress notes, in order for a provider to claim reimbursement for direct support provided to DDDS consumers, the provider must have documentation that the direct care staff met the following conditions:

- Was employed as a direct care employee of the provider agency and met all the requirements for training, background checks, etc. as demonstrated by personnel files;
- Was scheduled as a direct care worker and worked during the time invoiced as demonstrated by staff attendance records;
- Was compensated by the provider for direct care work as demonstrated by payroll documentation.

The billable units for waiver services are as follows:

Waiver Service	Billable Unit
Day Services	
Day Habilitation	15 minutes or per diem
Prevocational Service	15 minutes or per diem
Vocational Services	
Supported Employment – Individual	15 minutes
Supported Employment – Group	15 minutes
Residential Habilitation	
Neighborhood Group Home	per diem
Community Living Arrangement	per diem
Shared Living	per diem
Clinical Consultation	
Behavioral	15 minutes
Nursing	15 minutes
Supported Living	hour
Respite: self-directed	hour
Respite HHA/PASA	hour
Respite shared living or community facility	hour
Respite: ICF-IID facility	per diem
Respite Camp	visit
Personal Care: self-directed	hour
Personal Care HHA/PASA	hour
Community Transition	per transition
Home and Vehicle Accessibility Adaptions	per item
Specialized Medical Equipment & Supplies	per item
Assisted Technology Assessment/training	15 minutes
Assisted Technology Equipment	per item

Delaware Medicaid Enterprise System (DMES) Pricing Logic: For all DDDS Lifespan Waiver services, the DMES is programmed to use the rate on the prior authorization to price the claims, as opposed to using a rate in a table. If there is no unit cost rate on the prior authorization, the DMES will default to the "rate on file". The rate on file for all DDDS Lifespan Waiver services that may be different from member to member, which includes all of the services that can be claimed as a per diem, the rate on file in the MMIS is $1. If a provider submits a claim for which the paid unit rate is $1, this is an indication that the prior authorization was not set up correctly. The DMES pricing logic for DDDS Lifespan Waiver claims

causes the DMES to pay the lesser of the billed amount or the rate on the prior authorization or the rate on file if there is no prior authorization.

5.6 Prior Authorization

All DDDS Lifespan Waiver and State Plan Rehab services must be prior authorized by DDDS. DDDS enters prior authorizations into the DMES for all waiver services.

5.7 Provider Billing - Specific Guidance for Individual Services

Day Habilitation (including Community Participation) and Prevocational Service:

The maximum number of direct support hours a consumer can receive of Day Habilitation and/or Prevocational Services within a 5.5 hour “program day” is determined by the ICAP scores with exceptions granted by the Day Services staff as needed and supported by documentation. Service authorizations are typically made as a Per Diem, but in the cases where the participant is also authorized for Supported Employment Services (Split Services) the authorizations are made in 15 minute units. The prior authorization created for each consumer indicates the maximum amount that can be billed for a specified period of time. It is not a guarantee of payment for the entire amount authorized. Claims may only be submitted for hours of direct support actually provided.

The transportation add-on may only be billed for days when transportation is actually provided. If a transportation add-on is included in a prior authorization for a day service based on an expectation of the delivery of a transportation service each day but transportation is not actually delivered a particular day, the provider can still bill the correct amount for the service, not including the transportation add-on and the claim will process correctly because of the DMES Pricing Logic described above.

Supported Employment – Individual and Group:

Individual Supported Employment Services are expected to be provided only for as long as necessary. A goal to decrease professional supports and increase natural supports must be a standard part of every individual’s plan.

Individual Supported Employment Services assist the participant to become more independent in all aspects of their employment.

Individual Supported Employment Services assist the employer to become more independent in supporting all their employees including the participant who has a disability.

It is the expectation that services billed as Individual Supported Employment Services would include the participant; however, this does not exclude services provided "on behalf of" the participant as billable services.

Engaging the participant in the activity provides an opportunity for the person to learn, thus potentially becoming more independent in all aspects of their employment and reducing the need for professional supports.

Prior to providing and billing for services "on behalf of" the participant, the agency must first consider the following:

1) Why should this service be provided as "on behalf of" vs. engaging the participant?

2) Could the participant benefit by increasing their knowledge/abilities if they were engaged in this activity?

3) Would engaging the participant in this activity increase the employer's ability to support their employee without professional supports in the future?

It is recommended that agencies clearly document when billing for services provided as "on behalf of" the participant, and include a brief justification for why the services were provided as "on behalf of" vs engaging the participant.

Supported Employment – Small Group

Agencies will bill based on the staffing ratio for each consumer in 15-minute units, for services provided to the consumer while working at a community work site, in a group setting, where the consumer is earning minimum wage or higher.

Expected staffing ratios will be authorized by the DDDS Day Services Unit. One full year of units will be authorized by the Day Services Unit for the expected staffing ratio. Additional units will be authorized for group supported employment ratios above or below the primary ratio, as applicable to the individual's specific employment or support needs.

"Split Service" Billing

Members may choose to split their day between an employment-related service and a day service. Effective January 1, 2012, the DDDS Lifespan Waiver was amended to create the ability for providers to bill each of the day services in

increments smaller than a per diem to enable consumers to receive more than one service in a single day. This is referred to this as "split services." The maximum number of direct support hours a consumer can receive of each service within a 5.5 hour "program day" is still determined by the ICAP scores, with exceptions granted by the Day Service staff as needed. Therefore, the total number of hours billed per day for a consumer who splits their services should be no more than the hours that would be billed and paid if they were billing the service as a per diem, i.e. the maximum number of hours as determined by the ICAP. (Billing in 15-minute increments as opposed to per diem billing can actually result in the number of hours slightly exceeding the number of ICAP assessed hours due to the fixed length of the 15-minute units.)

Example:

Consumer A is authorized for 3.0 hours of day service direct support but has chosen to split their time between Supported Employment and Prevocational service. Initially, the authorized units are split evenly between the two services, with prior authorizations created for each service based on an assumption of 1.5 hours per day for each service (the distribution between the two services can be adjusted by the day program staff per the consumer's preference). The provider may only bill, however, for the number of direct support hours actually provided to the consumer, up to a maximum of 3.0 hours per day. The billing might, therefore, look like this:

1.5 hours = 6 15-minute SE units x $12.44 = $74.64

1.5 hours = 6 15-minute PV units x $7.61 = $45.66 (consumer chooses facility-based with transportation)

Total Payment $120.30

In the case of the split service example above, the provider should be prepared to document that they provided 1.5 hours of 1:1 job coaching to the consumer for part of the day and 1.5 hours of direct support for the part of the program day that the consumer spent in the Prevocational program. The direct support hours occur within the program day. Therefore, it is expected that the duration of the program day will be greater than the number of direct support hours billed for that day.

Clinical Consultation: Behavioral

Provision of a direct client service is not billable under this service.

Examples of activities that are billable under this waiver service include:

- Performing Functional Behavior Assessments;
- Writing behavior plans;
- Conferring with program staff or other team members regarding the development or implementation of the behavior plan;
- Training program staff on how to implement behavior plans in a residential or day setting;

- Attending consumer team and person-centered planning meetings;
- Obtaining consumer consents for rights restrictions or psychotropic medications;
- Conducting site visits at residential or day program sites to monitor implementation of the behavior plan.

Nurse Consultation

Provision of a direct consumer service is not billable under this service.

Examples of activities that are billable under this waiver service include:

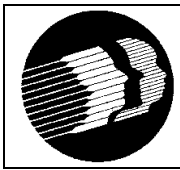
- Conducting the annual Nursing Assessment;
- Creating a monthly nursing note/house audit;
- Consultations with physicians and other health care practitioners or pharmacists;
- Reviewing periodicity schedules for routine health screenings and ensuring that necessary appointments are scheduled;
- Completing Medication Administration Records;
- Attending consumer team and person-centered planning meetings;
- Training program staff on how to implement behavior plans in a residential or day setting.

The authorized number of hours of Nurse Consultation is determined by a nursing assessment performed for each waiver recipient by the state using a standardized instrument.

Residential Services: The DDDS contracts contain additional requirements for residential providers related to the billing for site costs and other costs that are not Medicaid reimbursable and related to the management of member funds.

Supported Living: Supported Living is billed per hour.

Self-Directed Services: Individuals may elect to self-direct their respite or personal care services. Self-directed waiver services are managed by a broker under the Agency With Choice (AWC) model of self-direction. The AWC broker is responsible for making payments that comply with Internal Revenue Service and US DOL rules to caregivers chosen by the individual to deliver respite or personal care. The broker will then submit claims to Medicaid to recoup the cost of payments they have made to the caregiver. The AWC Broker will be paid a flat fee per member per month in which they make payments on behalf of the waiver participant as a Medicaid administrative expense.



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HCPCS Procedure Codes for DDDS Lifespan Waiver and State Plan Day Habilitation Services

7.0 Appendix B – HCPCS Procedure Codes

The following procedure codes are to be used for billing services under the Home and Community-Based Waiver for the Developmentally Disabled. To assure that the correct procedure code is used when billing the DMAP, the provider should check the heading at the top of each column.

The same set of procedure codes are used for both Waiver and State Plan Services, with the Modifier "U9" added as necessary to indicate that a service is provided to a recipient who is not enrolled in the DDDS Lifespan Waiver. Concurrent with amendment to the DDDS Lifespan Waiver effective 10/1/13, add codes to distinguish claims for Group Supported Employment from Individual Supported Employment.

For services billed as a per diem, only one claim can be submitted per consumer per date of service. Split Day Services MUST be billed using a 15-minute code.

Waiver Codes (taxonomy 103TM1800X)

Code Effective 7/1/13	DDDS/DMMA Definition	Literal HCPCS Description
G0175	Clinical Consultation: Behavioral – per 15 minutes	Scheduled interdisciplinary team conference (minimum of three exclusive of patient care nursing staff) with patient Present.
S5140	Shared Living/Adult Foster Care – Over 21	Foster Care, adult; per diem
S5145	Shared Living/Adult Foster Care – Under 21	Foster Care, therapeutic, child; per diem
T1001	Clinical Consultation: Nursing – per 15 minutes	Nursing assessment /evaluation
T2014	Prevocational, waiver; per diem	Habilitation, Prevocational, waiver; per diem
T2015	Prevocational, waiver; per 15 minutes	Habilitation, Prevocational, waiver; per hour
T2016	Community Living Arrangement	Habilitation, residential; waiver; per diem
T2019 U1	Individual Supported Employment, waiver; per 15 minutes	Habilitation, supported employment, waiver; per 15 minutes

T2019 UN	Group Supported Employment, waiver; per 15 minutes – 2 consumers	Habilitation, supported employment, waiver; per 15 minutes. Two patients served
T2019 UP	Group Supported Employment, waiver; per 15 minutes – 3 consumers	Habilitation, supported employment, waiver; per 15 minutes. Three patients served
T2019 UQ	Group Supported Employment, waiver; per 15 minutes – 4 consumers	Habilitation, supported employment, waiver; per 15 minutes. Four patients served
T2019 UR	Group Supported Employment, waiver; per 15 minutes – 5 consumers	Habilitation, supported employment, waiver; per 15 minutes. Five patients served
T2019 US	Group Supported Employment, waiver; per 15 minutes – 6 consumers	Habilitation, supported employment, waiver; per 15 minutes. Six or more patients served
T2019 U7	Group Supported Employment, waiver; per 15 minutes – 7 consumers	Habilitation, supported employment, waiver; per 15 minutes. Medicaid Level of Care 7, as defined by each State
T2019 U8	Group Supported Employment, waiver; per 15 minutes – 8 consumers	Habilitation, supported employment, waiver; per 15 minutes. Medicaid Level of Care 8, as defined by each State
T2020	Day Habilitation, waiver; per diem	Day Habilitation, waiver; per diem
T2021	Day Habilitation, waiver; per 15 minutes	Day Habilitation, waiver; per 15 minutes
T2025	Neighborhood Group Home	Waiver Services; not otherwise specified (NOS)
*T2013	Supported Living	Habilitation, educational, waiver; per hour
**T1005 U2	Respite Self-Directed per hour	Respite Care services, up to 15 minutes
**T1005 PC	Respite, Home Health Agency	Respite Care services, up to 15 mins
**T1005 U1	Respite, PASA, per hour	Respite Care services, up to 15 mins
**H0045 U1	Respite, ICF/IID, per diem	Respite Care, not in the home, per diem
**H0045 U2	Respite Care, camp, per visit	Respite Care, not in the home, per Camp
**H0045 U3	Respite Care, Shared Living, per hour	Respite Care, not in the home, per hour
**H0045 U4	Respite Care, Res Hab Agency, per hour	Respite Care, not in the home, per hour
**T1019 U2	Personal Care, Self-Directed, per hour	Personal Care Services, per 15 minutes

**T1019 PC	Personal Care, Home Health, per hour	Personal Care Services, per 15 mins
**T1019 U1	Personal Care, PASA, per hour	Personal Care Services, per 15 mins
**S5165	Home/Vehicle modification	Home Modifications; per service
**T2039	Home/Vehicle modification	Vehicle Modifications, waiver; per service
97165	Occupational Therapy Assessment, 15 minutes	Occupational Therapy Assessment
97168	Occupational Therapy Re-Assessment, 15 minutes	Occupational Therapy Re-Assessment
97755 GO	Occupational Therapist AT Assessment-Licensed, 15 minutes	Assistive technology assessment
97755 GP	Physical Therapist AT Assessment-Licensed, 15 minutes	Assistive technology assessment
97755 EY	AT Assessment-Non-Licensed, 15 minutes	Assistive technology assessment
S9445 GO	Patient Education, Licensed OT, 15 minutes	Patient Education, not otherwise classified, non-physician provider, individual per session
S9445 GP	Patient Education, Licensed PT, 15 minutes	Patient Education, not otherwise classified, non-physician provider, individual per session
S9445 EY	Patient Education, Non-Licensed, 15 minutes	Patient Education, not otherwise classified, non-physician provider, individual per session
**T2028	Assistive Technology Equipment DME Provider, per item	Specialized supply, not otherwise specified, waiver
**T1999	Assistive Technology Equipment (Non-Traditional)	Specialized supply, not otherwise specified, waiver

**K0739	Repair or Nonroutine Service of AT equipment, per repair	Repair or non-routi eservice for DME
**T2029	Specialized Medical Equipment and Supplies	Specialized medical equipment, not otherwise specified, waiver
**T2038	Community Transition	Community transition, waiver; per service
**H2015 U1	Community Participation – 1 Consumer	Comprehensive community support services, per 15 minutes
**H2015 U2	Community Participation – 2 Consumers	Comprehensive community support services, per 15 minutes

* Effective for DOS on or after 7/1/14, as approved by CMS in the renewal of the DDDS Lifespan Waiver.
**Effective for DOS on or after 7/1/17.

State Plan Procedure Codes under the Rehabilitation Option (taxonomy 103TR0400X)

These codes are used when billing for consumers who are receiving Day Habilitation services under the State Plan Rehabilitative Option but who are not currently enrolled in the DDDS HCBS waiver.

Code Effective 7/1/13	DDDS/DMMA Definition	Literal HCPCS Description
H2023 U1	Individual Supported Employment, per 15 minutes	Supported employment, per 15 minutes
H2023 UN	Group Supported Employment, per 15 minutes – 2 consumers	Supported employment, per 15 minutes, two patients served
H2023 UP	Group Supported Employment, per 15 minutes – 3 consumers	Supported employment, per 15 minutes, three patients served
H2023 UQ	Group Supported Employment, per 15 minutes – 4 consumers	Supported employment, per 15 minutes, four patients served
H2023 UR	Group Supported Employment, per 15 minutes – 5 consumers	Supported employment, per 15 minutes, five patients served
H2023 US	Group Supported Employment, per 15 minutes – 6 consumers	Supported employment, per 15 minutes, six patients served
H2023 U7	Group Supported Employment, per 15 minutes – 7 consumers	Supported employment, per 15 minutes, Medicaid Level of Care 7, as defined by each State
H2023 U8	Group Supported Employment, per 15 minutes – 8 consumers	Supported employment, per 15 minutes, Medicaid Level of Care 8, as defined by each State
T2014 U9	Prevocational, per diem. Non-waiver	Habilitation, Prevocational, waiver; per diem. Medicaid Level of Care 9, as defined by each State
T2015 U9	Prevocational, per 15 minutes. Non-waiver	Habilitation, Prevocational, waiver; per hour. Medicaid Level of Care 9, as defined by each State
T2020 U9	Day Habilitation, per diem. Non-waiver	Day Habilitation, waiver; per diem. Medicaid Level of Care 9, as defined by each State
T2021 U9	Day Habilitation, per 15 minutes. Non-waiver	Day Habilitation, waiver; per 15 minutes. Medicaid Level of Care 9, as defined by each State