



DEC 20 2017

Administrator
Washington, DC 20201

Kara Odom Walker, MD, MPH, MSHS
Secretary
Delaware Health and Social Services
P.O. Box 906
New Castle, DE 19720

Dear Dr. Odom Walker:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) approves your request, received on September 29, 2017, to amend the "Diamond State Health Plan (DSHP)" section 1115 Medicaid demonstration (project no. 11-W-00036/4) to add coverage of certain former foster care youth. Approval of this demonstration amendment is granted under the authority of section 1115(a) of the Social Security Act (the Act) and is based on the determination that the expenditure and waiver authorities granted therein are likely to assist with promoting the objectives of title XIX of the Act. This approval is effective as of the date of this letter through December 31, 2018.

With this demonstration amendment, Delaware is authorized to provide Medicaid state plan coverage to former foster care youth under age 26 who were in foster care under the responsibility of another state or tribe when they "aged out" of foster care at age 18 (or such higher age as elected by the other state) and were enrolled in Medicaid at that time. In accordance with our November 21, 2016 Center for Medicaid & CHIP Services Informational Bulletin (CIB), Delaware is providing Medicaid eligibility for these former foster care youth from a different state through concurrent section 1115(a) demonstration authority and Medicaid State Plan authority provided by section 1902(a)(10)(A)(ii)(XX) of the Act. CMS's approval of this demonstration amendment is conditioned upon approval of Delaware's corresponding Medicaid state plan amendment, which will be approved with an effective date of January 1, 2018. CMS is providing that correspondence separately.

All Medicaid title XIX requirements as expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in these approval documents shall apply to the DSHP demonstration. The state's authority to deviate from Medicaid requirements is limited to the specific authorities described in the enclosed approval documents and to the purpose indicated.

CMS's approval of this demonstration amendment is conditioned upon continued compliance with the enclosed set of Special Terms and Conditions (STCs) and associated authorities that have been revised to include coverage of "out-of-state" former foster care youth. The expenditure authorities remain unchanged but are enclosed with the updated STCs.

This award is subject to our receiving your written acknowledgement of the award and acceptance of the STCs and associated authorities within 30 days of the date of this letter.

Your CMS project officer, Ms. Robin Magwood, is available to answer any questions you may have related to the demonstration. Ms. Magwood can be reached at (410)786-0130 or Robin.Magwood@cms.hhs.gov. Correspondence concerning the demonstration can be mailed to Ms. Magwood at:

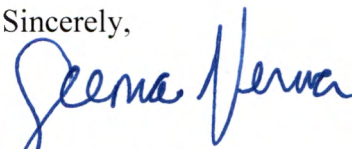
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
State Demonstrations Group
7500 Security Boulevard, Mailstop: S2-03-17
Baltimore, MD 21244-1850

Official communications regarding demonstration program matters should be sent simultaneously to Ms. Magwood and to Mr. Francis McCullough, Associate Regional Administrator (ARA) for the Division of Medicaid and Children's Health in our Philadelphia Regional Office. Mr. McCullough's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid & Children's Health
The Public Ledger Building
Suite 216
150 South Independence Mall West
Philadelphia, PA 19106

If you have questions regarding this correspondence, please contact Mrs. Judith Cash, Acting Director, State Demonstrations Group, Center for Medicaid & CHIP Services, at (410)786-9686.

Sincerely,



Seema Verma

Enclosures

cc: Francis McCullough, ARA, CMS Philadelphia Regional Office
Michael Cleary, State Lead, CMS Philadelphia Regional Office

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00036/4

TITLE: Delaware Diamond State Health Plan

AWARDEE: Delaware Department of Health & Social Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Delaware’s Diamond State Health Plan (DSHP) section 1115(a) Medicaid demonstration (hereinafter “demonstration”). The parties to this agreement are the Delaware Department of Health & Social Services (“state”) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state’s obligations to CMS during the life of the demonstration. The STCs are effective as of the date of the approval letter, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This demonstration extension is approved through December 31, 2018.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Eligibility
- V. DSHP Benefits
- VI. DSHP-Plus Benefits
- VII. Cost Sharing
- VIII. DSHP and DSHP-Plus Enrollment
- IX. Delivery Systems
- X. HCBS Service Delivery and Reporting Requirements
- XI. Family Planning Expansion Program
- XII. General Reporting Requirements
- XIII. General Financial Requirements
- XIV. Monitoring Budget Neutrality
- XV. Evaluation of the Demonstration
- XVI. Schedule of State Deliverables During the Demonstration Extension Period
- Attachment A. Quarterly Report Content and Format
- Attachment B. Historical Budget Neutrality Data
- Attachment C. DSHP-Plus HCBS Service Definitions
- Attachment D. HCBS Participant Safeguards
- Attachment E. Level of Care Criteria

II. PROGRAM DESCRIPTION AND OBJECTIVES

The DSHP section 1115(a) demonstration is designed to use a managed care delivery system to create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance. The initial demonstration was approved in 1995 to mandatorily enroll most Medicaid recipients into managed care organizations (MCOs) beginning January 1, 1996. Using savings achieved under managed care, Delaware expanded Medicaid health coverage to uninsured Delawareans with incomes up to 100 percent of the federal poverty level (FPL) and provides family planning coverage to women losing Medicaid pregnancy coverage at the end of 60 days postpartum or losing DSHP comprehensive benefits and have a family income at or below 200 percent of the FPL. The demonstration was previously renewed on June 29, 2000, December 12, 2003, December 21, 2006, and January 31, 2011.

Through an amendment approved by CMS in 2012, the state was authorized to expand the demonstration to create the Diamond State Health Plan Plus (DSHP-Plus) to mandate care through MCOs for additional state plan populations, including (1) individuals receiving care at nursing facilities (NF) other than intermediate care facilities for the mentally retarded (ICF/MR); (2) children in pediatric nursing facilities; (3) individuals who receive benefits from both Medicaid and Medicare (dual eligibles); and (4) workers with disabilities who Buy-In for coverage. This amendment also added eligibility for the following new demonstration populations: (1) individuals who would previously have been enrolled through the 1915(c) home and community based services (HCBS) waiver program for the Elderly and Disabled (waiver number 0136) – including those receiving services under the Money Follows the Person demonstration; (2) individuals who would previously have been enrolled through the 1915(c) HCBS waiver for Individuals with Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus (HIV/AIDS) Related Diseases (waiver number 4159); (3) individuals residing in NF who no longer meet the current medical necessity criteria for NF services; and (4) adults and children with incomes below 250 percent of the Supplemental Security Income Federal Benefit Rate who are at risk for institutionalization. Additionally, this amendment expanded HCBS to include: (1) cost-effective and medically necessary home modifications; (2) chore services; and (3) home delivered meals.

Through the renewal approved in 2013, the demonstration was amended to provide demonstration authority to extend the low income adult demonstration population up to individuals with incomes up to 100 percent of the FPL until December 31, 2013. After that date, the demonstration population was not necessary because it was included under the approved state plan as the new adult eligibility group authorized under the Affordable Care Act (ACA). The newly eligible adult group, for individuals with incomes up to 133 percent of the FPL, will receive medical assistance through enrollment in managed care plans pursuant to this demonstration. In addition, due to the health care coverage expansion, the family planning expansion program expired December 31, 2013.

Through an amendment approved by CMS on December 19, 2014, the state implemented a new program entitled Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE). PROMISE is a program that provides enhanced behavioral health

benefits for Medicaid enrollees, including, but not limited to those identified through the state's *Olmstead* settlement with the Department of Justice (DOJ). PROMISE enrollees include Medicaid beneficiaries who have a severe and persistent mental illness (SPMI) and/or a substance use disorder (SUD) and require Home and Community Based Services (HCBS) to live and work in integrated settings.

This amendment, submitted September 29, 2017, provides the state with the authority to add coverage of former foster care youth, defined as individuals under age 26 who were in foster care in another state or tribe when they turned 18 (or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Social Security Act (the Act)), were enrolled in Medicaid at that time, and are now residents in Delaware applying for Medicaid. This authority is contingent on the approval of the corresponding State Plan Amendment (SPA).

The state's goal in implementing the demonstration is to improve the health status of low-income Delawareans by:

- Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to HCBS;
- Rebalancing Delaware's LTC system in favor of HCBS;
- Promoting early intervention for individuals with, or at-risk, for having, LTC needs;
- Increasing coordination of care and supports;
- Expanding consumer choices;
- Improving the quality of health services, including LTC services, delivered to all Delawareans;
- Creating a payment structure that provides incentives for resources to shift from institutions to community-based LTC services where appropriate;
- Improving coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles;
- Expanding coverage to additional low-income Delawareans;
- Improving overall health status and quality of life of the individuals enrolled in the PROMISE program; and,
- Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are

part), must apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the time frames specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy statement affecting the Medicaid or CHIP program that occur during this demonstration approval period, unless the provision being changed is expressly identified as not applicable.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change.
 - b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI State Plan Amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid State Plan or CHIP State Plan is affected by a change to the demonstration, a conforming amendment to the state plan may be required, except as otherwise noted in these STCs.
6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.
7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:
 - a. An explanation of the public process used by the state, consistent with the

- requirements of STC 15, to reach a decision regarding the requested amendment;
- b. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
 - c. An up-to-date CHIP allotment neutrality worksheet, if necessary;
 - d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation, including a conforming Title XIX and/or Title XXI state plan amendment, if necessary; and
 - e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.
8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets federal requirements at 42 Code of Federal Regulations (CFR) section 431.412(c) or a transition and phase-out plan consistent with the requirements of STC 9.
9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.
- a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration’s suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation SPA. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state’s response to the comment and how the state incorporated the received comment into a revised phase-out plan.
 - b. The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

- c. Phase-out Plan Requirements. The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary’s appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
 - d. Phase-out Procedures. The state must comply with all notice requirements found in 42 CFR §§431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §§431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
 - e. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.
10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.
11. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.
12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS’ determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.
13. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the public notice procedures set forth in 42 CFR section 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR section 431.408(b), State Medicaid Director Letter #01-024, and contained in the state's approved Medicaid State plan, when any program changes to the demonstration, either through amendment as set out in STC 6 or extension, are proposed by the state.

15. **Post Award Forum:** Within six months of the demonstration's implementation and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medicaid Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of the STC. The state must include a summary in the quarterly report, as specified in STC 64, associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required by STC 65.
16. **Federal Financial Participation (FFP).** No federal matching for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.
17. **Medicaid Statistical Information System (MSIS) and T-MSIS (Transformed MSIS) Data Submission.** The state shall submit its MSIS data electronically to CMS in accordance with CMS requirements and timeliness standards, including the required transition to T-MSIS.

IV. ELIGIBILITY

The DSHP demonstration includes four distinct components: 1) The DSHP Medicaid managed care program provides Medicaid state plan benefits through a comprehensive managed care delivery system to most recipients eligible under the state plan. 2) The DSHP-Plus program provides long-term care services and supports (LTSS) to certain individuals under the State Plan, and to certain demonstration populations. Further details on these programs are provided in Table A, Sections V through X of the STCs. 3) Beginning January 1, 2015, the PROMISE program provides enhanced behavioral health services fee-for-service (FFS) to Medicaid beneficiaries with a higher level of behavioral health needs and functional limitations who need HCBS to live and work in integrated settings. 4) Effective as of the date of the corresponding State Plan Amendment (SPA) (targeted for January 1, 2018),

coverage for former foster care youth under age 26 who were in foster care under the responsibility of another state or tribe when they “aged out” of foster care at age 18 (or such higher age as elected by the state), were enrolled in Medicaid at that time, and are now residents in Delaware applying for Medicaid. This authority is contingent on the approval of the corresponding SPA.

18. **Use of Modified Adjusted Gross Income (MAGI) Based Methodologies For Eligibility Groups Affected By the Demonstration.** Mandatory and optional state plan groups described below derive their eligibility through the Medicaid State Plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State Plan, except as expressly waived in this demonstration and as described in these STCs. Any Medicaid State Plan Amendments to the eligibility standards and methodologies for these eligibility groups, including the conversion to a MAGI standard January 1, 2014, will apply to this demonstration. These state plan eligible beneficiaries are included in the demonstration for use of the managed care network and access to additional benefits not described in the state plan.

Table A. Overview of Eligibility for DSHP and DSHP-Plus

Note: All eligibility groups outlined in the below chart are mandatorily enrolled into managed care with the exception of the Family Planning Expansion Group. The eligibility groups receive DSHP and/or DSHP-Plus benefit package as outlined in sections V and VI based on the eligibility criteria.

State Plan Mandatory Medicaid Eligibility Groups	Description	FPL	Resource Standard	Medicaid Eligibility Group (MEG)	Retroactive Eligibility Procedures	DSHP Benefit Package	DSHP-Plus Benefit Package*	Alternative Benefits Plan Package
Qualified Pregnant Women and Children	§ 1902(a)(10)(A)(i)(III) § 1902(r)(2)	Children: Up to 100% of the FPL Pregnant Women: AFDC limit 59% of the FPL	n/a	<u>If age 20 and under:</u> DSHP TANF Children <u>If age 21 and over:</u> DSHP TANF Adults	n/a	X		
Pregnant women	§ 1902(a)(10)(A)(i)(IV)	Up to 185% of the FPL	n/a	<u>If age 20 and under:</u> DSHP TANF Children <u>If age 21 and over:</u> DSHP TANF Adults	n/a	X		
Infants less than one year old	§ 1902(a)(10)(A)(i)(IV)	Up to 185% of the FPL	n/a	DSHP TANF Children	n/a	X		
Children ages 1 through 5 years	§ 1902(a)(10)(A)(i)(VI)	Up to 133% of the FPL	n/a	DSHP TANF Children	n/a	X		
Children ages 6	§ 1902(a)(10)(A)(i)(VII)	Up to 100% of the	n/a	DSHP	n/a	X		

State Plan Mandatory Medicaid Eligibility Groups	Description	FPL	Resource Standard	Medicaid Eligibility Group (MEG)	Retroactive Eligibility Procedures	DSHP Benefit Package	DSHP-Plus Benefit Package*	Alternative Benefits Plan Package
through 18 years		FPL		TANF Children				
SSI Adults without Medicare	§1902(a)(10)(A)(i)(I)	Supplemental Security Income (SSI) standard	\$2,000 individual \$3,000 couple	DSHP SSI Adults	n/a	X	X	
SSI Children without Medicare	§1902(a)(10)(A)(i)(I)	SSI standard	\$2,000 individual	DSHP SSI Children	n/a	X	X	
Section 4913 Children – lost SSI because of the PRWORA disability definition	§1902(a)(10)(A)(II)	SSI standard	\$2,000 individual	DSHP SSI Children	n/a	X		
Section 1931 Families	§1931 Supplement 12 to Attachment 2.6-A, Page 2	Up to 75% of the FPL (AFDC standard)	n/a	<u>If age 20 and under:</u> DSHP TANF Children <u>If age 21 and over:</u> DSHP TANF Adults	n/a	X		
Child or spousal support extension	§1902(a)(10)(A)(i)(I)	n/a	n/a	<u>If age 20 and under:</u> DSHP TANF Children <u>If age 21 and over:</u> DSHP TANF Adults	n/a	X		
Transitional	§1925	Up to 185% of the	n/a	DSHP	n/a	X		

State Plan Mandatory Medicaid Eligibility Groups	Description	FPL	Resource Standard	Medicaid Eligibility Group (MEG)	Retroactive Eligibility Procedures	DSHP Benefit Package	DSHP-Plus Benefit Package*	Alternative Benefits Plan Package
Medical Assistance		FPL		TANF Child or Adult				
Title IV-E foster care and adoption assistance	§1902(a)(10)(A)(I)	n/a	n/a	DSHP TANF Child	n/a	X		
Postpartum medical assistance	§1902(e)(5)	n/a	n/a	DSHP TANF Child or Adult	n/a	X		
Continuous eligibility for pregnancy and postpartum period	§1902(e)(6)	n/a	n/a	DSHP TANF Child or Adult	n/a	X		
Deemed newborns	§1902(e)(4)	n/a	n/a	DSHP TANF Children	n/a	X		
Disabled working individuals receiving SSI	1619(a)	Under our 1634 agreement, SSA determines eligibility for this group. SSI standard for unearned income. Gross earnings must be at or above the substantial gainful activity level for non-blind individuals and blind individuals	\$2,000 individual \$3,000 couple	DSHP SSI Child or Adult		X		
1619(b)	§1902(a)(10)(A)(i)(II)	SSA determines eligibility for this group. SSI standard for unearned income. Gross earnings must meet the threshold test	\$2,000 individual \$3,000 couple	DSHP SSI Child or Adult	n/a	X		

State Plan Mandatory Medicaid Eligibility Groups	Description	FPL	Resource Standard	Medicaid Eligibility Group (MEG)	Retroactive Eligibility Procedures	DSHP Benefit Package	DSHP-Plus Benefit Package*	Alternative Benefits Plan Package
		for section 1619(b) eligibility.						
Disabled Adult Children	§1634(c)	SSI standard	\$2,000 individual \$3,000 couple	DSHP SSI Child or Adult	n/a	X		
Individuals ineligible for SSI/SSP because of requirements prohibited under Medicaid	42 CFR 435.122	SSI standard	\$2,000 individual \$3,000 couple	DSHP SSI Child or Adult	n/a	X		
Mandatory State supplements	42 CFR 435.130	SSA determines eligibility. SSI standard +mandatory state supplement.	\$2,000 individual \$3,000 couple	DSHP SSI Child or Adult	n/a	X		
Pickle amendment	P.L. 94-566 Sec. 503 42 CFR 435.135	SSI standard	\$2,000 individual \$3,000 couple	DSHP SSI Child or Adult	n/a	X		
Disabled widows/widowers	§1634(b) 42 CFR 435.137	SSI standard	\$2,000 individual \$3,000 couple	DSHP SSI Adults	n/a	X		
Disabled early widows/widowers	§1634(d) 42 CFR 435.138	SSI standard	\$2,000 individual \$3,000 couple	DSHP SSI Adults	n/a	X		
SSI Adults with Medicare	§1902(a)(10)(A)(i)(I)	SSI standard	\$2,000 individual \$3,000 couple	DSHP-Plus State Plan	n/a	X	X	
SSI Children with Medicare	§1902(a)(10)(A)(i)(I)	SSI standard	\$2,000	DSHP-Plus State Plan	n/a	X	X	
Newly Eligible Group – ages 19 - 64 (Effective January 1, 2014)	§1902(a)(10)(A)(i)(VIII) 42 CFR 435.119	Up to 133% of the FPL	n/a	DSHP Adult Group	1 st day of the month that application is submitted			X

State Plan Optional Medicaid Eligibility Groups	Description	FPL	Resource Standard	MEG	Retroactive Eligibility Procedures	DSHP Benefit Package	DSHP-Plus Benefit Package
Optional Pregnant women	§1902(a)(10)(A)(ii)(IX) §1902(r)(2)	Above 185 through 200% FPL	n/a	<u>If age 20 and under:</u> DSHP TANF Children <u>If age 21 and over:</u> DSHP TANF Adults	n/a	X	
Optional Infants less than one year old: Optional targeted low-income children	§1902(a)(10)(A)(ii)(IX) §1902(r)(2)	<ul style="list-style-type: none"> Children above 185% through 200% may be funded with Title XXI funds if they are uninsured. Insured children are Title XIX. The State receives Title XXI funds for expenditures for uninsured children meeting the definition specified in section 2110(b)(1) of the Act. Title XIX funds are available if the State exhausts its Title XXI allotment and for insured children. (no Title XIX funds have been used to date) 	n/a	DSHP MCHP	n/a	X	
Reasonable Classifications of children under age 21 for whom public agencies are assuming full or partial financial	1902(a)(10)(A)(ii)(I) and (IV); 42 CFR 435.222	Up to 75% of the FPL (AFDC income standard)	AFDC resource standard	DSHP TANF Children	n/a	X	

State Plan Optional Medicaid Eligibility Groups	Description	FPL	Resource Standard	MEG	Retroactive Eligibility Procedures	DSHP Benefit Package	DSHP-Plus Benefit Package
responsibility as outlined in the Medicaid State plan.							
TEFRA Children (Katie Beckett)	§1902(e)(3)	Up to 250% of SSI Standard	\$2,000	DSHP SSI Children	n/a	X	
Eligible for cash except for institutional status	§1902(a)(10)(A)(ii)(IV)	SSI standard for ABD AFDC standard for pregnant women and parents/caretaker relatives	For ABD: \$2,000 individual \$3,000 couple AFDC standard for pregnant women and parents/caretaker relatives	DSHP SSI Child or Adult	n/a	X	
Subsidized adoption children under the age of 21 with special medical needs	§1902(a)(10)(A)(ii)(VIII)	n/a	n/a	DSHP TANF Children	n/a	X	
Optional State supplement – individuals living in an adult residential care facility or assisted living facility	§1902(a)(10)(A)(ii)(IV) 42 CFR 435.232	Individual: SSI standard + \$140 Couple: SSI standard +\$448	\$2,000 individual \$3,000 couple	DSHP SSI Children or Adults	n/a	X	X
Optional State supplement – individuals who lose eligibility for Medicaid due to receipt of SSDI and are not yet eligible for Medicare	§1902(a)(10)(A)(ii)(IV) 42 CFR 435.232	\$5.00 month	n/a	DSHP SSI Children or Adults	n/a	X	X
Institutionalized individuals in Nursing Facilities who meet the Nursing Facility LOC criteria in place at the	§1902(a)(10)(A)(ii)(V)	Up to 250% of SSI Standard	\$2,000 individual \$3,000 couple	DSHP-Plus State Plan	3 months prior to application month	X	X

State Plan Optional Medicaid Eligibility Groups	Description	FPL	Resource Standard	MEG	Retroactive Eligibility Procedures	DSHP Benefit Package	DSHP-Plus Benefit Package
time of enrollment into the facility (with and without Medicare) even if they later do not meet the current LOC criteria							
Medicaid for Workers with Disabilities (Medicaid Buy-in)	§1902(a)(10)(A)(ii)(XV)	Up to 275% of the FPL	n/a	DSHP-Plus State Plan	3 months prior to the application month	X	X
Optional Group of Individuals above 133 percent of the FPL	§1902(a)(10)(ii)(XX)	Above 133% of the FPL	n/a	DSHP FFCY	n/a	X	

Demonstration Eligible Groups	Description	FPL	Resource Standard	MEG	Retroactive Eligibility Procedures	DSHP Benefit Package	DSHP-Plus Benefit Package
TEFRA-Like Children (Katie Beckett) using the “at-risk of NF” LOC criteria in place at time of enrollment	§1902(e)(3) Children, ages 18 or younger, who are disabled as described in section 1614(a) of the Social Security Act, who do not meet the NF LOC, but who in the absence of receiving care are “at-risk” of institutionalization and meet an “at-risk of NF” LOC. Use financial institutional eligibility rules for individuals who would not be eligible in the community because of community deeming rules.	Up to 250% of SSI Standard	\$2,000	DSHP TEFRA-Like	n/a	X	
Aged and/or disabled categorically needy individuals over age 18 who meet the Nursing Facility LOC criteria in place at the time of HCBS enrollment and receive HCBS as an alternative (formerly served through an Elderly & Physically Disabled 1915c Waiver)	Use institutional eligibility and post eligibility rules for individuals who would not be eligible in the community because of community deeming rules in the same manner as specified under 42 CFR 453.217, 435.236, and 435.726 of the Federal regulations and 1924 of the Social Security Act, if the State had a 1915(c) waiver program.	Up to 250% of SSI Standard	\$2,000 individual \$3,000 couple	DSHP-Plus HCBS	n/a	X	X
Individuals with a diagnosis of AIDs or HIV	Use institutional eligibility and post eligibility rules for	Up to 250% of SSI Standard	\$2,000 individual \$3,000 couple	DSHP-Plus HCBS	n/a	X	X

Demonstration Eligible Groups	Description	FPL	Resource Standard	MEG	Retroactive Eligibility Procedures	DSHP Benefit Package	DSHP-Plus Benefit Package
over age 1 who meet the Hospital LOC criteria and who receive HCBS as an alternative (formerly served through an AIDS/HIV 1915c Waiver)	individuals who would not be eligible in the community because of community deeming rules in the same manner as specified under 42 CFR 453.217, 435.236, and 435.726 of the Federal regulations and 1924 of the Social Security Act, if the State had a 1915(c) waiver program.						
Aged and/or disabled individuals over age 18, who do not meet a NF LOC, but who, in the absence of HCBS, are “at-risk” of institutionalization and meet the “at-risk” for NF LOC criteria in place at the time of enrollment and who need/are receiving HCBS	§1115 Use financial institutional eligibility and post-eligibility rules for individuals who would not be eligible in the community because of community deeming rules in the same manner that would be used if the State had a 1915(c) program.	Up to 250% of SSI Standard	\$2,000 individual \$3,000 couple	DSHP-Plus HCBS	n/a	X	X

* Any individual needing Nursing Facility services and is eligible for such services will receive Nursing Facility services through DSHP-Plus.

19. **Eligibility Exclusions.** Notwithstanding Table A, the following persons are excluded from this demonstration.

Table B. Eligibility Exclusions.

Exclusions from DSHP and DSHP-Plus	Description	FPL	Resource Standard	Retroactive Eligibility Procedures
PACE	§1934	Up to 250% of SSI Standard	\$2,000 individual \$3,000 couple	n/a
Qualified Medicare Beneficiaries (QMB)	§1902(a)(10)(E)(i) §1902(r)(2) used to disregard all resources	Up to 100% of the FPL	\$6,680 individual \$10,202 couple	n/a
Specified Low Income Medicare Beneficiary (SLMB)	§1902(a)(10)(E)(iii) §1902(r)(2) used to disregard all resources	Up to 120% of the FPL	\$6,680 individual \$10,202 couple	3 months prior to application month
Qualifying Individuals (QI)	§1902(a)(10)(E)(iv) §1902(r)(2) used to disregard all resources	Up to 135% of the FPL	\$6,680 individual \$10,202 couple	3 months prior to application month
Qualified and Disabled Working Individuals	§1902(a)(10)(E)(ii) §1902(r)(2) used to disregard all resources	Up to 200% of the FPL	\$4,000 individual \$6,000 couple	3 months prior to application month
Presumptively eligible pregnant women	§1902(a)(47) §1920	Up to 185% of the FPL	n/a	n/a
Individuals in a hospital for 30 consecutive days*	§1902(a)(10)(A)(ii)(V)	SSI standard	\$2,000	3 months prior to the application months
Presumptive Breast and Cervical Cancer for Uninsured Women	§1920B	n/a	n/a	3 months prior to application month
Breast and Cervical Cancer Program for women	§1902(a)(10)(A)(ii)(XVIII)	n/a	n/a	3 months prior to application month
Institutionalized individuals in an ICF/MR facility	§1902(a)(10)(A)(ii)(V)	250% of SSI Standard	\$2,000 individual \$3,000 couple	3 months prior to application month
Community-based individuals who meet ICF/MR level of care	§1902(a)(10)(A)(ii)(VI)	250% of SSI Standard	\$2,000 individual \$3,000 couple	n/a

Exclusions from DSHP and DSHP-Plus	Description	FPL	Resource Standard	Retroactive Eligibility Procedures
(DDDS/MR 1915c Waiver)				

* Individuals who are eligible for Medicaid under 42 CFR 435.236 by virtue of the fact that they are in the hospital for period of not less than 30 consecutive days will be excluded from enrollment in DSHP or DSHP-Plus during the period of continuous hospitalization. When this population is ready for discharge, the state will determine whether they meet income and resource criteria under any other Medicaid eligibility categories and their need for continued services such as out of state rehabilitation facilities or LTC services in the community. Their eligibility category determined at that point would determine whether they would be enrolled in the demonstration per the attached eligibility matrix. During the period when the client may not enroll in the demonstration, their hospital stay will be covered fee for service.

20. **Eligibility and Post Eligibility Treatment of Income for DSHP-Plus Individuals who are Institutionalized.** The state must follow the rules specified in the currently approved State plan for institutionalized DSHP-Plus participants. All individuals receiving institutional services must be subject to post eligibility treatment of income rules set forth in section 1924 of the Social Security Act and 42 CFR §435.725 of the federal regulations.
21. **Regular and Spousal Impoverishment Post-Eligibility Treatment of Income for DSHP-Plus Individuals Receiving HCBS (Specified at 42 CFR §435.726 of the Federal Regulations and 1924 of the Social Security Act).** For HCBS participants found eligible using institutional eligibility rules and that do not receive services in an Assisted Living Facility, the state will provide a maintenance needs allowance that is equal to the individuals' total income as determined under the post eligibility process, which includes income that is placed in a Miller Trust. For those HCBS participants that elect to receive services in an Assisted Living Facility, the state will provide a maintenance needs allowance set at the Adult Foster Care Rate, which is the SSI standard plus the Optional State Supplement amount.

For HCBS participants residing in Assisted Living Facilities, the state must provide the MCOs the set of unique taxonomies and procedure codes that the state currently uses to identify HCBS services. The MCOs will instruct HCBS providers to use this set of codes when billing them for HCBS so that they can identify HCBS in their claims processing systems. This way MCOs can ensure that the patient liability amount assessed for each Assisted Living client is only applied toward the cost of HCBS and not to regular state plan services. The state must also include language in the MCO contract specifying the requirement that patient liability only be applied to the cost of HCBS.

22. **Eligibility for the PROMISE Program.** The PROMISE program begins January 1, 2015. DSHP and DSHP-Plus eligible beneficiaries and enrollees applying for services must be screened by the Division of Substance Abuse and Mental Health (DSAMH) using a standardized clinical and functional assessment developed for Delaware and based on national standards. See Attachment F for a detailed explanation of clinical and functional assessments that are used in the screening process.
23. **Eligibility for Former Foster Care Youth (FFCY).** Individuals eligible as "former foster care youth" are defined as individuals under age 26 who were in foster care in another state or tribe when they turned 18 (or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Social Security Act (the Act)), were enrolled in Medicaid at that time, and are now residents in Delaware applying for Medicaid.

V. DSHP BENEFITS

24. **DSHP Benefits.** Benefits provided through this demonstration for the Medicaid managed care and Family Planning Expansion Programs are described below:
 - a. **DSHP Benefits.** As outlined in Table A, all mandatory and optional state plan and

demonstration-eligible populations, with the exception of the Family Planning Expansion Program, are entitled to receive all mandatory and optional services under the approved Medicaid state plan. These Medicaid state plan benefits are provided through a combination of contracts with managed care organizations or managed care delivery systems, as well as FFS, for specific services noted below.

- b. **DSHP FFS Benefits.** The following state plan services are carved out from the Medicaid MCO benefit package and are paid on a FFS basis:
- i. Pharmacy;
 - ii. Child dental;
 - iii. Non-emergency transportation, except for emergency ambulance transportation;
 - iv. Day habilitation services authorized by the Division of Developmental Disabilities Services;
 - v. Medically necessary behavioral health services for both children and adults in excess of MCO plan benefit coverage, which is 30 visits for children and 20 visits for adults
 - vi. Prescribed pediatric extended care.

25. **Alternative benefit plan:** The Newly Eligible Group, made eligible under the state plan effective January 1, 2014, will receive benefits described in the state's approved alternative benefit plan (ABP) state plan amendment (SPA), which are effective, as of the effective date in the approved ABP SPA.

26. **Self-Referral.** Demonstration beneficiaries may self-refer for the following services:

- Emergency care;
- Family planning services, including obstetric and gynecology services;
- For female participants, the MCOs must allow direct access to women's health specialists within the health plan's network for covered care related to women's routine and preventive care;
- In-network behavior health services;
- In-network eye health care services for children, including optometry and ophthalmology;
- Evaluation Services from a provider with the Early Childhood Intervention program for children ages 0-3 years with a developmental delay; and
- Generally all specialists (except Neuro-psych).

27. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).** The MCOs must fulfill the state's responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions).

VI. DSHP-PLUS BENEFITS

28. **Eligibility for DSHP-Plus HCBS Benefits.** DSHP-Plus provides HCBS LTSS as identified in Table C to eligible individuals as outlined in Table A. Medical and/or

functional needs are assessed according to LOC criteria for NFs, hospitals and “at-risk of NF” criteria published in the state rules. These criteria must be based on accepted medical standards. These LOC criteria must be used in assessing eligibility for DSHP-Plus HCBS benefits at the time of an individual’s initial HCBS enrollment. Attachment E outlines the LOC criteria for NFs and hospitals in effect prior to implementation of DSHP-Plus within the demonstration and the LOC criteria for NFs, hospitals, and “at-risk of NF” criteria for initial implementation of DSHP-Plus. The state is required to notify CMS 60 days in advance of any changes to these LOC criteria and provide an update to this attachment.

29. **DSHP-Plus HCBS Benefit Package.** The following Table C describes the additional benefits available to HCBS participants, that are provider-directed and, if the participant elects the option, self-directed. The services are further defined in Attachment C.

Table C. DSHP-Plus HCBS

Service	Provider Directed	Participant Directed
Case Management	X	
Community Based Residential Alternatives	X	
Personal Care/Attendant Care	X	X
Respite	X	
Adult Day Services	X	
Day Habilitation	X	
Cognitive Services	X	
Personal Emergency Response System	X	
Support for Participant Direction	X	
Independent Activities of Daily living (Chore)	X	
Nutritional Supports	X	
Specialized Medical Equipment &Supplies	X	
Minor Home Modifications	X	
Home Delivered Meals	X	

30. **Option for Participant Direction of Personal Care Services.** DSHP-Plus participants who elect self-directed care must have the opportunity to have choice and control over how personal care services are provided and who provides the service. Member participation in participant direction is voluntary, and members may participate in or withdraw from participant direction at any time.

- a. **Information and Assistance in Support of Participant Direction.** The state/MCO shall have a support system that provides participants with information, training, counseling, and assistance, as needed or desired by each participant, to assist the participant to effectively direct and manage their self-directed services and budgets. Participants shall be informed about self-directed care, including feasible alternatives, before electing the self-direction option. Participants shall also have access to the support system throughout the time that they are self-directing their care. Support activities must include, but is not limited to Support for Participant Direction service which includes two components: Financial Management Services and Support

Brokerage. Providers of Support for Participant Direction must carry out activities associated with both components. The Support for Participant Direction service provides assistance to participants who elect to self-direct their personal care services.

- b. **Participant Direction by Representative.** The participant who self-directs the personal care service may appoint a volunteer designated representative to assist with or perform employer responsibilities to the extent approved by the participant. Waiver services may be directed by a legal representative of the participant. Waiver services may be directed by a non-legal representative freely chosen by an adult participant. A person who serves as a representative of a participant for the purpose of directing personal care services cannot serve as a provider of personal attendant services for that participant.
- c. **Participant Employer Authority.** The participant (or the participant's representative) must have decision-making authority over workers who provide personal care services.
 - i. Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide personal care services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.
 - ii. Decision Making Authorities. The participant exercises the following decision making authorities: Recruit staff, select staff from worker registry, hire staff as common law employer, verify staff qualifications, obtain criminal history and/or background investigation of staff, specify additional staff qualifications based on participant needs and preferences, evaluate staff performance, verify time worked by staff and approve time sheets, and discharge staff.
- d. **Disenrollment from Participant-Direction.** A participant may voluntarily disenroll from the self-directed option at any time and return to a traditional service delivery system. To the extent possible, the member shall provide his/her personal care provider ten (10) days advance notice regarding his/her intent to withdraw from participant direction. A participant may also be involuntarily disenrolled from the self-directed option for cause, if continued participation in the participant-directed services option would not permit the participant's health, safety, or welfare needs to be met, or the participant demonstrates the inability to self-direct by consistently demonstrating a lack of ability to carry out the tasks needed to self-direct personal care services, or if there is fraudulent use of funds such as substantial evidence that a participant has falsified documents related to participant directed services. If a participant is terminated voluntarily or involuntarily from the self-directed service delivery option, the MCO must transition the participant to the traditional agency direction option and must have safeguards in place to ensure continuity of services.

- e. **Appeals.** The following actions shall be considered an adverse action under both 42 CFR 431 Subpart E (state fair hearing) and 42 CFR §438 Subpart F (MCO grievance process):
 - i. A reduction in services; or
 - ii. A denial of a requested adjustment to the care plan.

Participants may use either the state fair hearing process or the MCO appeal process to request reconsideration of these adverse actions.

- 31. **Money Follows the Person (MFP) Demonstration.** Beneficiaries enrolled in the state's MFP program are included in the demonstration. MFP grant funds must pay for MFP services for MFP-eligible participants.

The MCOs will provide MFP Transition Coordinators and Nurses that will develop transition plans and assist MFP eligible clients in transitioning from institutions to the facility. The MCOs will contract with and reimburse current MFP service vendors. State staff will oversee the MCOs and approve all transition plans developed by the MCOs and approve all discharges.

VII. PROMISE BENEFITS

- 32. **DSHP and DSHP-Plus Benefits.** Individuals enrolled in PROMISE will receive all of their DSHP or DSHP-Plus state plan benefits through the MCOs, just as the individuals had before enrollment in PROMISE. However, DSHP beneficiaries who are enrolled in PROMISE, will have a DSAMH counselor as their primary case manager. DSHP-Plus beneficiaries will continue to have the MCO case manager act as their primary; the DSAMH counselor will be the secondary case manager. Individuals enrolled in PROMISE and eligible for DSHP and DHSP Plus but not yet enrolled in an MCO may receive all of their state plan benefits through FFS while awaiting enrollment in the MCO.
- 33. **PROMISE Benefits.** Beneficiaries enrolled in PROMISE receive all of the following non-state plan benefits through the program (definitions of these services are found in Attachment F):
 - a. Benefits counseling
 - b. Case management
 - c. Community-based residential alternative supports that exclude assisted living
 - d. Community transition services
 - e. CPST/PSR and other services by non-licensed clinic staff including evidence-based practices, such as assertive community treatment (ACT) and intensive case management (ICM)
 - f. Financial coaching
 - g. Non-medical transportation
 - h. Nursing
 - i. Peer supports
 - j. Personal care

- k. Respite
- l. Skill-building for individual activities of daily living/chore
- m. Supported employment (both individual and small group)

In addition, the individuals will receive the behavioral health state plan benefits of substance use disorder including medication assisted treatment (MAT) and services by licensed behavioral health practitioners through the PROMISE program.

VIII. COST SHARING

- 34. Co-payments will be charged to all DSHP and DSHP-Plus Managed Care enrollees as stipulated in the state plan. Standard Medicaid exemptions from cost-sharing, such as family planning services, as stipulated in 42 C.F.R. §447(b), apply to the demonstration.

IX. ENROLLMENT

35. Mandatory Enrollment.

- a. **Enrollment.** The state may mandatorily enroll individuals served through this demonstration in managed care programs to receive DSHP and DSHP-Plus benefits pursuant to Sections V, VI and VIX of the STCs. The mandatory enrollment will apply only when the plans in the geographic area have been determined by the state to meet certain readiness and network requirements and require plans to ensure sufficient access, quality of care, and care coordination for beneficiaries established by the state, as required by 42 C.F.R §438 and approved by CMS. The state must provide updates through its regular meetings with CMS and submit regular documentation requested of its Readiness Review status.
- b. **Choice.** The state must ensure that at the time of initial enrollment and on an ongoing basis, the individuals have a minimum of two plans meeting all readiness requirements from which to choose. If at any time, the state is unable to offer two plans, an alternative delivery system must be available within 60 days of loss of plan choice.
- c. **Notice Requirement for a Change in Network.** The state must provide notice to CMS as soon as it becomes aware of (or at least 90 days prior if possible) a potential change in the number of plans available for choice within an area, or any other changes impacting proposed network adequacy. The State may not mandatorily enroll individuals into any plan that does not meet network adequacy requirements as defined in 42 CFR §438.206.

- 36. **DSHP Enrollment Process.** All individuals must have the opportunity to make an active selection of a DSHP MCO prior to enrollment. The state will pre-select an MCO for each DSHP member. That pre-selection shall be based on 42 CFR §438.56, taking into account the MCO affiliation of the individual's historic providers, including those for HCBS services. Once the member is advised of the state's pre-selection, the member will have up to 30 days to choose another MCO. If a different MCO is not selected during that time period, the member will be enrolled into the pre-selected MCO.

37. **DSHP-Plus Enrollment Process.** All individuals must have the opportunity to make an active selection of a DSHP-Plus MCO prior to enrollment. However, similar to DSHP members, the state will pre-select an MCO for each DSHP-Plus member. That pre-selection shall be based on 42 CFR §438.56, taking into account the MCO affiliation of the individual's historic providers, including those for HCBS services. Once the member is advised of the state's pre-selection, the member will have up to 30 days to choose another MCO. If a different MCO is not selected during that time period, the member will be enrolled into the pre-selected MCO.
38. **DSHP and DSHP-Plus Disenrollment.** Individuals must be informed at least annually of their opportunity to change MCOs. Within 90 days of their initial enrollment into an MCO, individuals must be permitted 90 days to change MCOs without cause. After that time period, MCO changes are permitted for cause only.
39. **PROMISE Enrollment.** Starting January 1, 2015, MCOs may not apply limits on medically necessary covered behavioral health services. If a beneficiary's care coordinator believes that individual would benefit from a more targeted behavioral health program, the coordinator will contact the designated DSAMH contact. A DSAMH care manager will arrange to meet the beneficiary and assess the beneficiary's eligibility for the PROMISE program based on the standardized assessment tool in Attachment D. If the individual meets the criteria for enrollment into the program, the individual can choose whether to enroll in the program, as enrollment is strictly voluntary. Individuals enrolled in this program will receive the benefits outlined in Attachment F.

X. DELIVERY SYSTEMS

40. **Managed Care Requirements.** The state must comply with the managed care regulations published at 42 CFR §438, except as waived herein. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR §438.6. The certification shall identify historical utilization of state plan and HCBS services used in the rate development process.
41. **Managed Care Benefit Package.** Individuals enrolled in any managed care program within the state must receive from the managed care program the benefits as identified in Sections V and VI of the STCs. As noted in plan readiness and contract requirements, the state must require that each MCO refer and/or coordinate, as appropriate, enrollees' access to needed state plan services that are excluded from the managed care delivery system but available through a fee-for-service delivery system, and must also assure referral and coordination with services not included in the established benefit package.
42. **Managed Care Contracts.** No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR §438 requirements prior to CMS approval of such contracts and/or contract amendments. The State shall submit any supporting documentation deemed necessary by CMS. The state must provide CMS with a minimum of 60 days to review and approve changes. CMS reserves the right, as a corrective

action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.

43. **Open Enrollment Period.** During the period from May 15, 2014 through September 30, 2014, the state may delay the annual open enrollment opportunity that otherwise would have been available to beneficiaries during this enrollment period, in order to realign its annual managed care open enrollment period with the Federally-Facilitated Marketplace (the Marketplace) open enrollment period provided for enrollment in a qualified health plan and the 2014 managed care organization (MCO) procurement cycle. During this period the state must:
 - a. Notify the beneficiaries of the change of open enrollment date;
 - b. Allow disenrollment for any reason; and
 - c. Continue to monitor beneficiary access to services through the state's and MCO member services lines.
44. **Procurement.** Should the state not continue with an existing contracted MCO during the 2014 procurement process, the state shall ensure that beneficiaries are able to continue receiving services as specified in 42 CFR §438.62. When enrolling a beneficiary with a new MCO through auto-assignment process the state will ensure that the historical provider-beneficiary relationship is preserved in accordance with 42 CFR §438.50(f)(2).
45. **Public Contracts.** Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).
46. **Network Requirements.** The state must ensure the delivery of all covered benefits, including high quality care. Services must be delivered in a culturally competent manner, and the MCO network must be sufficient to provide access to covered services to the low-income population. In addition, the MCO must coordinate health care services for demonstration populations. The following requirements must be included in the state's MCO contracts:
 - a. **Special Health Care Needs.** Enrollees with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 C.F.R. §438.208(c)(4).
 - b. **Out of Network Requirements.** Each MCO must provide demonstration populations with all demonstration program benefits described within these STCs and must allow access to non-network providers when services cannot be provided consistent with the timeliness standards required by the state.

47. **Demonstrating Network Adequacy.** Annually, each MCO must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate range of preventive, primary, pharmacy, specialty and HCBS services for the anticipated number of enrollees in the service area.
- a. The state must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:
 - i. The number and types of primary care, pharmacy, and specialty providers available to provide covered services to the demonstration population
 - ii. The number of network providers accepting the new demonstration population; and
 - iii. The geographic location of providers and demonstration populations, as shown through GeoAccess or similar software.
 - b. The state must submit the documentation required in subparagraphs i – iii above to CMS with initial MCO contract submission as well as at each contract renewal or renegotiation, or at any time that there is a significant impact to each MCO’s operation, including service area expansion or reduction and population expansion.
48. **Revision of the State Quality Strategy.** The state must update its Quality Strategy to reflect all managed care plans operating under the DSHP and DSHP-Plus programs. The state must obtain the input of recipients and other stakeholders in the development of its revised comprehensive Quality Strategy and make the Strategy available for public comment. The state must revise the strategy whenever significant changes are made, including changes through this demonstration. Pursuant to STC 66, the state must also provide CMS with annual reports on the effectiveness of the updated comprehensive Quality Strategy as it impacts the demonstration.
49. **Required Components of the State Quality Strategy.** The revised Quality Strategy shall meet all the requirements of 42 CFR §438 Subpart D. The quality strategy must include components relating to HCBS and must address the following: administrative authority, level of care determinations, service plans, health and welfare, and qualified providers. Additionally, it must also include information on how the state will monitor and evaluate each MCO’s compliance with the contract requirements specific to the DSHP-Plus program as outlined in STC 57, including level of care evaluations, service plans, qualified providers as well as how the health and welfare of enrollees will be assessed and monitored.
50. **Required Monitoring Activities by State and/or External Quality Review Organization (EQRO).** The state’s EQRO process shall meet all the requirements of 42 CFR §438 Subpart E. In addition, the state, or its EQRO, shall monitor and annually evaluate the MCOs’ performance on specific new requirements under DSHP-Plus. These include but are not limited to the following:
- a. Level of care determinations – to ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals being served with LTSS have been assessed to meet the required level of care for those services.

- b. Service plans – to ensure that MCOs are appropriately creating and implementing service plans based on enrollee’s identified needs.
- c. MCO credentialing and/or verification policies – to ensure that HCBS services are provided by qualified providers.
- d. Health and welfare of enrollees – to ensure that the MCO, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

51. **Advisory Committee as required in 42 CFR §438.** The state must maintain for the duration of the demonstration a managed care advisory group comprised of individuals and interested parties impacted by the demonstration’s use of managed care, regarding the impact and effective implementation of these changes to seniors and persons with disabilities. Membership on this group should be periodically updated to ensure adequate representation of individuals receiving LTSS.

52. **Managed Care Data Requirements.** All managed care organizations shall maintain an information system that collects, analyzes, integrates and reports data as set forth at 42 CFR 438.242. This system shall include encounter data that can be reported in a standardized format. Encounter data requirements shall include the following:

- a. Encounter Data – All managed care organizations in the demonstration shall be responsible for the collection of all data on services furnished to enrollees through encounter data or other methods as specified by the state, and the maintenance of these data at the plan level. The state shall, in addition, develop mechanisms for the collection, reporting, and analysis of these, as well as a process to validate that each plan’s encounter data are timely, complete and accurate. The state will take appropriate actions to identify and correct deficiencies identified in the collection of encounter data. The state shall have contractual provisions in place to impose financial penalties if accurate data are not submitted in a timely fashion.
- b. Encounter Data Validation Study for New Capitated Managed Care Plans - If the state contracts with new managed care organizations, the state shall conduct a validation study 18 months after the effective date of the contract to determine completeness and accuracy of encounter data. The initial study shall include validation through a sample of medical records of demonstration enrollees.
- c. Submission of Encounter Data - The state shall submit encounter data to the Medicaid Statistical Information System (MSIS) and when required T-MSIS (Transformed MSIS) as is consistent with Federal law. The state must assure that encounter data maintained at managed care organizations can be linked with eligibility files maintained at the state.

53. **External Quality Review (EQR).** The state is required to meet all requirements for external quality review (EQR) found in 42 C.F.R. Part 438, subpart E. The state must amend its current external quality review organization (EQRO) contract to require the validation of encounter data for all MCOs and PIHPs a minimum of once every three years.

The state should generally have available its final EQR technical report to CMS and the public, in a format compliant with Section 508 of the Rehabilitation Act (29 U.S.C. § 794d), by April 30th of each year, for data collected within the prior 15 months. This submission timeframe will align with the collection and annual reporting on managed care data by the Secretary of Health and Human Services each September 30th, which is a requirement under the ACA [Sec. 2701 (d)(2)].

54. **PROMISE and MCO Care Coordination.** The state must assure that the MCOs coordinate, to the maximum extent possible, all services provided by the MCO (primary, acute, and any state plan behavioral health services) with the enhanced behavioral health services provided FFS by the PROMISE program. The state must submit a description of how all services will be coordinated within 30 days of approval of the PROMISE amendment.

XI. HCBS SERVICE DELIVERY AND REPORTING REQUIREMENTS

55. **Home and Community-Based Settings.** The state shall ensure that home and community-based settings must have all of the qualities required by 42 CFR 441.301(c)(4), and other such qualities as the secretary determines to be appropriate based on the needs of the individual as indicated in their person-centered plan. In a provider owned or controlled setting, the additional qualities required by CFR 441.301(c)(4)(vi) must be met.

56. **Administrative Authority.** When there are multiple state entities involved in the administration of the demonstration, The Single State Medicaid Agency must maintain ultimate authority over the program and must exercise appropriate monitoring and oversight over MCOs as well as all entities contracted to assigned administrative functions on behalf of the Medicaid Agency.

57. **Integration of Section 1915(c) Waiver Assurances and Program Requirements into DSHP-Plus.** CMS must expect the state to maintain administrative authority and to implement DSHP-Plus in such a way that the waiver assurances and other program requirements currently part of its 1915(c) waiver programs are met, either by the state or by the MCOs through specific contract provisions, as follows:

- a. Level of Care (LOC) and At-Risk Determinations.
 - i. An evaluation for level of care or at-risk determination must be given to all applicants for whom there is reasonable indication that services may be needed in the future either by the State, or as a contractual requirement, by the MCO or PROMISE program.
 - ii. All DSHP-Plus and PROMISE enrollees must be reevaluated at least annually or as otherwise specified either by the state, or as a contractual

requirement, by the MCO.

- iii. The LOC and at-risk process and instruments will be implemented as specified by the state, either through the state's own processes, or as a contractual requirement, by the MCO.

b. Person-Centered Planning and Individual Service Plans.

- i. The MCO contract and PROMISE program shall require the use of a person-centered and directed planning process as required by 42 CFR 441.301(c)(1), and intended to identify the strengths, capacities, and preferences of the enrollee as well as to identify an enrollee's long term care needs and the resources available to meet these needs, and to provide access to additional care options as specified by the contract. The person-centered plan is developed by the participant with the assistance of the team and those individuals, such as family, friends and professionals the participant chooses to include. The individual will have informed choices about treatment and service decisions. The plan includes the services and supports that the participant needs to live in the community.
- ii. The MCO contract and PROMISE program shall require that service plans must address all enrollees' assessed needs (including health and safety risk factors), preferences, choices abilities and personal goals and the strategies to address them.
- iii. The MCO contract and PROMISE program shall require that a process is in place that permits participants to request a change to the person-centered plan if the participant's circumstances necessitate a change. The MCO contract and PROMISE program shall require that all service plans are updated collaboratively and/or revised at least annually or when warranted by changes in the enrollee's needs and involve an ongoing commitment to the participant.
- iv. The MCO contract and PROMISE program shall require development of a back-up plan to ensure that needed assistance will be provided in the event that the regular services and supports identified in the individual service plan are temporarily unavailable. The back-up plan may include other individual assistants or services.
- v. The MCO contract and PROMISE program shall require that services be delivered in accordance with the service plan, including the type, scope, amount, and frequency.
- vi. The MCO contract and PROMISE program shall require that enrollees receiving HCBS services have a choice of provider within the MCO's network and PROMISE program, as applicable.
- vii. The MCO contract and PROMISE program shall require policies and procedures for the MCO and PROMISE performance improvement process to monitor appropriate implementation of the individual service plans.
- viii. The MCO contract and PROMISE program shall utilize the state established minimum guidelines as outlined in the approved MCO contracts and PROMISE manuals regarding:
 - The individuals who develop the person-centered service plan (and

their requisite qualifications);

- The individuals who are expected to participate in the plan development process;
- Types of assessments that are conducted as part of the service plan development process;
- How participants are informed of the services available to them;

c. Qualified Providers.

- i. The MCO provider credentialing requirement in 42 CFR §438.214 and HCBS provider qualification requirements in PROMISE shall apply to all HCBS providers. If the state wishes to change provider qualification standards from those that exist under waivers #0136 and #4159, the state must reach agreement with CMS to do so and ensure that the new standards preserve health and welfare. The state is required to report any changes in provider qualification standards as a part of the quarterly monitoring calls and quarterly reports pursuant to STCs 64 and 65.
- ii. To the extent that the MCO's credentialing policies and procedures do not address non-licensed non-certified providers, the MCO shall create alternative mechanisms to ensure the health and safety of enrollees.

d. Health and Welfare of Enrollees. The MCO contract and PROMISE program shall require the MCO and PROMISE staff to, on a continuous basis, identify, address, and seek to prevent instances of abuse, neglect and exploitation.

e. Fair Hearings.

- i. All enrollees must have access to the state fair hearing process as required by 42 CFR §431 Subpart E. In addition, the requirements governing MCO appeals and grievances in 42 CFR §438 Subpart F shall apply for MCO covered benefits.
- ii. The MCO contract shall specify whether enrollees must exhaust the MCO's internal appeals process before exercising their right to a state fair hearing.
- iii. The MCO contract shall require the MCO to make whatever reasonable accommodations are necessary to ensure that enrollees have a meaningful opportunity to exercise their appeal and grievance rights.

58. Critical Incident Management System. The state must operate a critical incident management system according to the state's established policies, procedures and regulations (as described in Attachment D), including the requirement to report, document, and investigate incidents of abuse, neglect, and exploitation. The state must notify CMS of any changes to the policies, procedures and regulations. The MCO/state is required to analyze the critical incident data, track and trend, and make necessary changes in order to prevent reoccurrence.

59. State Grievance/Complaint System. The state must operate a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services.

60. **Freedom of Choice.** The MCO case managers must be required to inform each applicant or member of any alternatives available, including the choice of institutional care versus HCBS, during the assessment process. Documentation of choice must be incorporated into the Service Plan.

XII. GENERAL REPORTING REQUIREMENTS

61. **General Financial Requirements.** The state must comply with all general financial requirements under title XX set forth in Section XIV of these STCs.

62. **Compliance with Managed Care Reporting Requirements.** The state must comply with all managed care reporting regulations at 42 CFR §438 et. seq. except as expressly identified as not applicable in the expenditure authorities incorporated into these STCs.

63. **Reporting Requirements Related to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality set forth in Section XII of these STCs.

64. **Quarterly Monitoring Calls.** The state must participate in monitoring calls with CMS. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments, rate certifications, changes in provider qualification standards, on-going monitoring and oversight), health care delivery, enrollment, cost sharing, any proposed change to LOC criteria, quality of care, access, family planning issues, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, proposed changes in payment rates, MCO financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, any demonstration amendments, concept papers, or state plan amendments the state is considering submitting. The state and CMS shall discuss quarterly expenditure reports submitted by the state for purposes of monitoring budget neutrality. CMS shall update the state on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

65. **Quarterly Reports.** The state must submit progress reports in the format specified in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:

- a. An updated budget neutrality monitoring spreadsheet;
- b. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: systems and reporting issues, approval and contracting with new plans; benefits; enrollment; grievances; proposed or implemented LOC changes; quality of care; changes in provider qualification standards; access; proposed changes to payment rates; health plan financial

- performance and the implementation of MLTSS, that is relevant to the demonstration; pertinent legislative activity; and other operational issues;
- c. Action plans for addressing any policy and administrative issues identified;
 - d. Network adequacy reporting from plans including GeoAccess mapping, customer service reporting including average speed of answer at the plans and call abandonment rates; summary of MCO appeals for the quarter including overturn rate and any trends identified; enrollee complaints and grievance reports to determine any trends; and summary analysis of MCO critical incident report which includes, but is not limited to, incidents of abuse, neglect and exploitation;
 - e. Quarterly enrollment reports that include the member months for each demonstration population;
 - f. Notification of any changes in enrollment and/or participation that fluctuate 10 percent or more in relation to the previous quarter within the same DY and the same quarter in the previous DY; and
 - g. Evaluation activities and interim findings, including lessons learned from the PROMISE program and the effect of the PROMISE program on beneficiary health outcomes and quality of life.

66. **Annual Report.** The annual report must, at a minimum, include the requirements outlined below. The state must submit the draft annual report no later than April 1 after the close of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

- a. All items included in the quarterly report pursuant to STC 65(a)-(d) and (f)-(h) must be summarized to reflect the operation/activities throughout the DY;
- b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;
- c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutral agreement;
- d. Quality Strategy. Pursuant to STC 49, the state must report on the effectiveness of the updated comprehensive Quality Strategy as it impacts the demonstration;
- e. Managed Care Delivery System. The state must document accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, progress on implementing cost containment initiatives and policy and administrative difficulties in the operation of the demonstration. The state must provide the CAHPS survey, outcomes of any focused studies conducted and what the

state intends to do with the results of the focused study, outcomes of any reviews or interviews related to measurement of any disparities by racial or ethnic groups, annual summary of network adequacy by plan including an assessment of the provider network pre and post implementation and MCO compliance with provider 24/7 availability, summary of outcomes of any on-site reviews including EQRO, financial, or other types of reviews conducted by the state or a contractor of the state, summary of performance improvement projects being conducted by the state and any outcomes associated with the interventions, outcomes of performance measure monitoring, summary of plan financial performance; and

- f. Family Planning Expansion Program. Additionally, for the Family Planning Expansion Program, the state must provide the following:
- i. The average total Medicaid expenditures for a Medicaid-funded birth each DY. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth up to age 1 (the services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants);
 - ii. The number of actual births that occur to family planning demonstration participants within the DY. (participants include all individuals who obtain one or more covered medical family planning services through the family planning program each year);
 - iii. Total number of participants for the DY (participants include all individuals who obtain one or more covered family planning services through the demonstration).

67. **Final Report.** Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments.

XIII. GENERAL FINANCIAL REQUIREMENTS

68. **Quarterly Reports.** The state must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XV of the STCs.

69. **Reporting Expenditures Under the Demonstration.** The following describes the reporting of expenditures subject to the budget neutrality agreement:

- a. Tracking Expenditures. In order to track expenditures under this demonstration, Delaware will report demonstration expenditures through the Medicaid and state Children's Health Insurance Program Budget and Expenditure System

(MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 and Section 2115 of the state Medicaid Manual. All demonstration expenditures subject to the budget neutrality limit must be reported each quarter on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on the appropriate prior period adjustment schedules (Forms CMS-64.9 Waiver) for the Summary Line 10B, in lieu of Lines 9 or 10C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the State Medicaid Manual. The term, “expenditures subject to the budget neutrality limit,” is defined below in Section XVI.

- b. Tracking Family Planning Expenditures. For the family planning expansion component of the demonstration, the state should report demonstration expenditures on Forms CMS-64.9 Waiver and/or 64.9P Waiver as follows:
 - i. Allowable family planning-related expenditures eligible for reimbursement at the state’s federal medical assistance percentage rate (FMAP) should be entered in Column (B) on the appropriate waiver sheets.
 - ii. Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate should be entered in Column (D) on the appropriate waiver sheets
- c. Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.
- d. Premium and Cost Sharing Contributions. Premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by DY on the Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration’s actual expenditures on a quarterly basis.
- e. Pharmacy Rebates. Pharmacy rebates must be reported on Form CMS-64.9 Base, and not allocated to any Form 64.9 or 64.9P Waiver.
- f. Mandated Increase in Physician Payment Rates in 2013 and 2014. Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires

state Medicaid programs to pay physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014. The federal government provides a Federal medical assistance percentage of 100 percent for the claimed amount by which the minimum payment exceeds the rates paid for those services as of July 1, 2009. The state will exclude from the budget neutrality test for this demonstration the portion of the mandated increase for which the federal government pays 100 percent.

g. Use of Waiver Forms. For each demonstration year, twelve (12) separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver name noted below, to report expenditures for the following demonstration populations, . Table A outlines the Medicaid eligibility group for each DSHP and DSHP-Plus eligibility group. The waiver names to be used to identify these separate Forms CMS-64.9 Waiver and/or 64.9P Waiver appear in brackets. Expenditures should be allocated to these forms based on the guidance found below.

- i. **Demonstration Population 1:** TANF Children less than 21
[DSHP TANF Children]
- ii. **Demonstration Population 2:** TANF Adults aged 21 and over
[DSHP TANF Adult]
- iii. **Demonstration Population 3:** Disabled Children less than 21
[DSHP SSI Children]
- iv. **Demonstration Population 4:** Aged and Disabled Adults 21 and older
[DSHP SSI Adults]
- v. **Demonstration Population 5:** Infants less than one year of age with income levels above 185 percent FPL through 200 percent FPL. See section (h) below for specific reporting guidelines.
[DSHP MCHP]
- vi. **Demonstration Population 6:** Uninsured Adults Expansion Population to 100 percent FPL [DSHP Exp. Pop.]
(NOTE: Expenditures for the expired Adults Demonstration population are reported here.)
- vii. **Demonstration Population 7:** Family Planning Expansion
[FP Expansion]
(NOTE: Expenditures for the expired Family Planning Expansion population are reported here.)

- viii. **Demonstration Population 8:** DSHP-Plus State Plan
 - ix. **Demonstration Population 9:** DSHP-Plus HCBS
 - x. **Demonstration Population 10:** DSHP TEFRA-Like
 - xi. **Demonstration Population 11:** DSHP Adult Group
(Starting January 1, 2014)
 - xii. **Demonstration Population 12:** PROMISE Services
(Starting January 1, 2015)
- h. **Specific Reporting Requirements for Demonstration Population 5.**
- i. As outlined in Table A, uninsured children above 185 percent through 200 percent of the FPL are funded with title XXI funds. Insured children above 185 percent through 200 percent of the FPL are funded with title XIX funds. The state is eligible to receive title XXI funds for expenditures for these uninsured children meeting the definition specified in section 2110(b)(1) of the Social Security Act, up to the amount of its title XXI allotment. Expenditures for these children under title XXI must be reported on separate Forms CMS-64.21U and/or 64.21UP in accordance with the instructions in section 2115 of the State Medicaid Manual.
 - ii. Title XIX funds for these uninsured children meeting the definition specified in section 2110(b)(1) of the Social Security Act are available under this demonstration if the state exhausts its title XXI allotment once timely notification as described in subparagraph (iii) has been provided.
 - iii. If the state exhausts its title XXI allotment prior to the end of a federal fiscal year, title XIX federal matching funds are available for these children. During the period when title XIX funds are used, expenditures related to this demonstration population must be reported as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver. To initiate this:
 - 1) The state shall provide CMS with 120 days prior notice before it begins to draw down title XIX matching funds for this demonstration population;
 - 2) The state shall submit:
 - a) An updated budget neutrality assessment that includes a data analysis which identifies the specific “with waiver” impact of the proposed change on the current budget neutrality expenditure cap. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current extension

approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as result of the proposed change which isolates (by Eligibility Group) the impact of the change;

b) An updated CHIP allotment neutrality worksheet.

iv. The expenditures attributable to this demonstration population will count toward the budget neutrality expenditure cap calculated under STC 69, using the per member per month (PMPM) amounts for TANF Children described in STC 83 and will be considered expenditures subject to the budget neutrality cap as defined in STC 83, so that the state is not at risk for claiming title XIX federal matching funds when title XXI funds are exhausted.

70. Expenditures Subject to the Budget Neutrality Cap. For purposes of this section, the term “expenditures subject to the budget neutrality cap” must include all Medicaid expenditures related to the demonstration benefit package described in sections V and VI of the STCs provided to individuals who are enrolled in this demonstration as described in STC 69(g)(i-xii), subject to the limitation specified in STC 69(h). All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

Expenditures for individuals enrolled in this demonstration as former foster care youth as described in STC 23 above, has been determined to be budget neutral based on CMS’ assessment that the waiver authorities granted to provide this demonstration population with Medicaid services are unlikely to result in any increase in federal Medicaid expenditures. There are no additional expenditure authorities associated with this demonstration population. The demonstration will not include a budget neutrality expenditure limit for this demonstration population, and no further test of budget neutrality will be required for this demonstration population. Accordingly, the state will not be allowed to obtain budget neutrality “savings” from providing Medicaid services to this demonstration population. All expenditures associated with the population of former foster care youth will be reported on the CMS-64 base form(s) for Medicaid State Plan populations in accordance with section 2500 of the State Medicaid Manual.

71. Title XIX Administrative Costs. Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

72. Claiming Period. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the

demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

73. Reporting Member Months. The following describes the reporting of member months for demonstration populations:

- a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 64, the actual number of eligible member months for the demonstration populations defined in STC 69(g)(i-xi). The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information. The member months in STC 69(g)(x) will be a duplicate of member months in other demonstration populations and will be omitted from any official tallies of member months under the demonstration.
- b. To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.
- c. The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member months.

74. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. Delaware must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make federal funds available based upon the state’s estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

75. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in Section XV of the STCs:

- a. Administrative costs, including those associated with the administration of the demonstration;
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

- c. Net medical assistance expenditures made under section 1115 demonstration authority under the demonstration.

76. Extent of Federal Financial Participation for Family Planning Expansion Program.

CMS shall provide FFP for family planning and family planning-related services and supplies described in section 1905(a)(4)(C) at the applicable 90 percent federal matching rates, subject to the limits and processes described below:

- a. For family planning services, reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service.
- b. Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate, should be entered in Column (D) on the Forms CMS-64.9 Waiver.
- c. Allowable family planning-related expenditures eligible for reimbursement at the FMAP, should be entered in Column (B) on the Forms CMS-64.9 Waiver.
- d. FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the 90 percent federal matching rate. The match rate for the subsequent treatment would be paid at the applicable federal matching rate for the state. For testing or treatment not associated with a family planning visit, no FFP will be available.
- e. Pursuant to 42 CFR §433.15(b)(2), FFP is available at the 90 percent administrative match rate for administrative activities associated with administering the family planning services provided under the demonstration including the offering, arranging, and furnishing of family planning services. These costs must be allocated in accordance with OMB Circular A-87 cost allocation requirements. The processing of claims is reimbursable at the 50 percent administrative match rate.

The Family Planning Expansion Program expired December 31, 2013. There will no longer be FFP for services provided if they are billed under this program after December 31, 2013.

77. Sources of Non-Federal Share. The state must certify that matching the non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a. CMS shall review the sources of the non-federal share of funding for the

demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.

- b. Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.
- c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

78. State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

- a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.
- b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.
- d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.
- e. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to

Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

79. **Monitoring the Demonstration.** The state will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.
80. **Program Integrity.** The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

XIV. MONITORING BUDGET NEUTRALITY

81. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.
82. **Risk.** Delaware shall be at risk for the per capita cost (as determined by the method described below) for demonstration eligibles under this budget neutrality agreement, but not for the number of demonstration eligibles. Because CMS provides FFP for all demonstration eligibles, Delaware shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Delaware at risk for the per capita costs for current eligibles, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures had there been no demonstration.
83. **Demonstration Populations Used to Calculate the Budget Neutrality Expenditure Cap.** For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described in the chart below. The federal share of this limit will be calculated by multiplying the total computable budget neutrality limit by Composite Federal Share, which is defined in section (a) below. The demonstration expenditures subject to the budget neutrality limit are those reported under the following Waiver Names (TANF, SSI, DSHP-Plus State Plan, and DSHP TEFRA-Like) plus any excess spending from the Supplemental Tests described in STC 84.

Eligibility Group	Growth Rate	DY 19 CY 2014 PMPM	DY 20 CY 2015 PMPM	DY 21 CY 2016 PMPM	DY22 CY 2017 PMPM	DY23 CY 2018 PMPM
Mandatory and Optional State Plan Groups						
DSHP TANF Children	5.00%	\$413.82	\$434.51	\$456.24	\$479.05	\$503.00
DSHP TANF Adult	5.16%	\$685.11	\$720.46	\$757.64	\$796.73	\$837.84
DSHP SSI Children	5.00%	\$2,360.45	\$2,478.47	\$2,602.39	\$2,732.51	\$2,869.14
DSHP SSI Adults	4.5%	\$2,404.12	\$2,512.31	\$2,625.36	\$2,743.50	\$2,866.96
DSHP-Plus State Plan	2.76%	\$2,528.14	\$2,597.92	\$2,669.62	\$2,743.30	\$2,819.02
Hypothetical Populations*						
DSHP Adult Group	5.1%	\$463.14	\$486.76	\$511.58	\$537.68	\$565.10
DSHP TEFRA-Like	5.00%	\$2,360.45	\$2,478.47	\$2,602.39	\$2,732.51	\$2,869.14
PROMISE	5.1%	N/A	\$1,233.54	\$1,296.45	\$1,362.56	\$1,432.05

* The Newly Eligible Group, DSHP TEFRA-Like, and PROMISE are “pass-through” or “hypothetical” populations. Therefore, the state may not derive savings from these populations.

- a. **Composite Federal Share.** The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the extension approval period, as reported on the forms listed in STC 68(g) above, by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period (see STC 11), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of the Composite Federal Share may be used.
- b. The overall budget neutrality expenditure cap for the demonstration is the sum of the annual budget neutrality expenditure caps calculated above. The federal share of the overall budget neutrality expenditure cap (calculated as the product of the overall budget neutrality cap times the Composite Federal Share) represents the maximum amount of FFP that the state may receive for expenditures on behalf of demonstration populations described in STC 69(g) during the demonstration period reported in accordance with STC 69.

84. Supplemental Budget Neutrality Test: Newly Eligible Group. Adults eligible for Medicaid as the group defined in section 1902(a)(10)(A)(i)(VIII) of the ACA are included in this demonstration, and in the budget neutrality. The state will not be allowed to obtain

budget neutrality “savings” from this population. Therefore, a separate expenditure cap is established for this group, to be known as the Supplemental Budget Neutrality Test.

- a. The MEG listed in the table below is included in Supplemental Budget Neutrality Test.

MEG	TREND	DY 19 CY 2014 PMPM	DY 20 CY 2015 PMPM	DY 21 CY 2016 PMPM	DY22 CY 2017 PMPM	DY23 CY 2018 PMPM
Newly Eligible Group	5.1%	\$463.14	\$486.76	\$511.58	\$537.68	\$565.10

- b. If the state’s experience of the take up rate for the Newly Eligible Group and other factors that affect the costs of this population indicates that the PMPM limit described above in paragraph (a) may underestimate the actual costs of medical assistance for the Newly Eligible Group, the state may submit an adjustment to paragraph (a) for CMS review without submitting an amendment pursuant to STC 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.
- c. The Supplemental Cap is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across groups and DYs. The federal share of the Supplemental Cap is obtained by multiplying total computable Supplemental Cap by the Composite Federal Share.
- d. Supplemental Budget Neutrality Test is a comparison between the federal share of the Supplemental Cap and total FFP reported by the state for Newly Eligible Group.
- e. If total FFP for Newly Eligible Group should exceed the federal share of Supplemental Cap after any adjustments made to the budget neutrality limit as described in paragraph b, the difference must be reported as a cost against the budget neutrality limit.

85. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

86. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state’s expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

Year	Cumulative target definition	Percentage
DY 19	Cumulative budget neutrality limit plus:	2.0 percent
DY 19 & 20	Cumulative budget neutrality limit plus:	1.5 percent
DY 19 through 21	Cumulative budget neutrality limit plus:	1.0 percent
DY 19 through 22	Cumulative budget neutrality limit plus:	0.5 percent
DY 19 through 23	Cumulative budget neutrality limit plus:	0 percent

87. **Expenditure Containment Initiatives.** In order to ensure that the demonstration remains budget neutral during the extension period, the state shall consider implementing new initiatives and/or strategies. Possible areas of consideration may include, but are not limited to, pharmacy utilization, MCO rates, benchmarking the services covered, expansion of co-pays and new initiatives related to behavioral health. The state will inform CMS of the cost-containment initiatives that it considers implementing and its progress through the quarterly and annual reports required under STCs 65 and 66, respectively.

88. **Exceeding Budget Neutrality.** If, at the end of this demonstration period, the cumulative budget neutrality expenditure cap has been exceeded, the excess federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

XV. EVALUATION OF THE DEMONSTRATION

89. **Submission of Draft Evaluation Design.** The state shall submit to CMS for approval within 120 days from the award of the demonstration extension a draft evaluation design. Within 120 days of the award of the demonstration amendment, the state must submit a revised draft evaluation design pursuant to subparagraph (a). At a minimum, the draft design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target populations for the demonstration. The draft design must discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The draft design must identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

- a. Domain of Focus: The Evaluation Design must, at a minimum, address the research questions/topics listed below and the goals of the demonstration as outlined in Section I of the STCs. For questions that cover broad subject areas, the state may propose a

more narrow focus of the evaluation.

- i. The impact of rebalancing the LTC system in favor of HCBS;
- ii. The costs and benefits of providing early intervention for individuals with, or at-risk, for having LTC needs;
- iii. The cost-effectiveness and efficiency of DSHP-Plus in ensuring that appropriate health care services are provided in an effective and coordinated fashion;
- iv. Effectiveness of the coordination of the MCO and DSAMH case managers, as well as the services provided by the MCO with the enhanced behavioral health services provided by PROMISE; and
- v. The extent to which the PROMISE services improve the overall health status and quality of life of the individuals enrolled in PROMISE.
- vi. The extent to which including former foster care youth who “aged out” of foster care in a different state increases and strengthens overall coverage for former foster care youth and improves health outcomes for these youth.

90. **Interim Evaluation Reports.** In the event the state requests to extend the demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of its request for each subsequent renewal.

91. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft evaluation design described in STC 89 within 60 days of receipt, and the state shall submit a final design within 60 days of receipt of CMS comments. The state must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The state must submit to CMS a draft of the evaluation report within 120 days after expiration of the demonstration. CMS must provide comments within 60 days after receipt of the report. The state must submit the final evaluation report within 60 days after receipt of CMS comments.

92. **Cooperation with CMS Evaluators.** Should CMS conduct an independent evaluation of any component of the demonstration, the state will cooperate fully with CMS or the independent evaluator selected by CMS. The state will submit the required data to the contractor or CMS.

XVI. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

The state is held to all reporting requirements as outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Date - Specific	Deliverable	STC Reference
90 days from January 1, 2014	Submit State Quality Strategy	Section X, STC 49
120 days from January 1, 2014	Submit Draft Evaluation Plan, including Evaluation Designs for DSHP and DSHP-Plus	Section XV, STC 89

60 days of receipt of CMS comments	Submit Final Evaluation Report	Section XV, STC 91
60 days prior to implementation of any LOC changes	LOC Criteria, required to share a revised Attachment E	Section VI, STC 28
30 days from approval date of the PROMISE amendment (December 19, 2014)	Description of how MCO and PROMISE services will be coordinated	Section X, STC 54

	Deliverable	STC Reference
Annual	By April 1 st - Draft Annual Report	Section XII, STC 66
Each Quarter (02/28, 05/31, 08/31, 11/30)	Quarterly Operational Reports	Section XII, STC 65
	Quarterly Enrollment Reports	Section XII, STC 65
	CMS-64 Reports	Section XIII, STC 69
	Eligible Member Months	Section XIII STC 73

ATTACHMENT A

Quarterly Report Content and Format

Under Section XII, STC 64, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

NARRATIVE REPORT FORMAT:

Title Line One – Diamond State Health Plan

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 12 (1/1/2007 – 12/31/2007)

Federal Fiscal Quarter: 1/2007 (1/07 - 3/07)

Introduction

Information describing the goals of the demonstration, what it does, and key dates of approval /operation (this should be the same for each report).

Enrollment Information

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by “0”.

Enrollment Counts

Note: Enrollment counts should be person counts, not member months

Demonstration Populations (as hard coded in the CMS 64)	Current Enrollees (to date)	Disenrolled in Current Quarter
<u>Population 1:</u> Former AFDC Children less than 21 [DSHP TANF Children]		
<u>Population 2:</u> Former AFDC Adults aged 21 and over [DSHP TANF Adult]		
<u>Population 3:</u> Disabled Children less than 21 [DSHP SSI Children]		
<u>Population 4:</u> Aged and Disabled Adults 21 and older [DSHP SSI Adults]		
<u>Population 5:</u> Infants less than one year of age with income levels above 185 percent FPL through 200 percent FPL: optional targeted low income children. [DSHP MCHP]		
<u>Population 6:</u> Uninsured Adults up to 100% FPL [DSHP Exp. Pop.]		

ATTACHMENT A

Quarterly Report Content and Format

Demonstration Populations (as hard coded in the CMS 64)	Current Enrollees (to date)	Disenrolled in Current Quarter
Population 7: Family Planning Expansion [FP Expansion]		
Population 8: DSHP-Plus State Plan		
Population 9: DSHP-Plus HCBS		
Population 10: DSHP TEFRA-Like		
Population 11: Newly Eligible Group		
Population 12: PROMISE		
Population 13: Former Foster Care Youth		

Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the current quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to, approval and contracting with new plans, benefit changes, enrollment; grievances; proposed or implemented LOC changes; quality of care; access; changes in provider qualification standards; access; proposed changes to payment rates; health plan financial performance that is relevant to the demonstration; and other operational issues. Also identify all significant policy and legislative developments/issues/problems that have occurred in the current quarter or anticipated to occur in the near future.

Expenditure Containment Initiatives

Identify all current activities, by program and or demonstration population. Include items such as status, and impact to date as well as short and long term challenges, successes and goals.

Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the state’s actions to address these issues.

Member Month Reporting

Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
DSHP TANF Children				
DSHP TANF Adult				
DSHP SSI Children				
DSHP SSI Adults				
DSHP MCHP (Title XIX				

ATTACHMENT A

Quarterly Report Content and Format

match)*				
DSHP Exp. Pop.				
FP Expansion				
DSHP-Plus State Plan				
DSHP-Plus HCBS				
DSHP TEFRA-Like				
Newly Eligible Group				
* This EG does not include children funded through title XXI. Please note within the report, if the state must use title XIX funds for other uninsured children meeting the definition specified in section 2110(b)(1) of the Social Security Act if the state exhausts title XXI funds.				

Eligibility Group	Total Member Months for the Quarter	PMPM	Total Expenditures (Member months multiplied by PMPM)
DSHP TANF Children			
DSHP TANF Adult			
DSHP SSI Children			
DSHP SSI Adults			
DSHP MCHP (Title XIX match)*			
DSHP Exp. Pop.			
FP Expansion			
DSHP-Plus State Plan			
DSHP-Plus HCBS			
DSHP TEFRA-Like			
Newly Eligible Group			
* This EG does not include children funded through title XXI. Please note within the report, if the state must use title XIX funds for other uninsured children meeting the definition specified in section 2110(b)(1) of the Social Security Act if the state exhausts title XXI funds.			

B. For Informational Purposes Only

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
DSHP MCHP (Title XXI match)				

Consumer Issues

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Also discuss feedback received from the MCARP and other consumer groups.

Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity in current quarter. As part of the annual report, pursuant to STCs 48 and 49, the state must also report on the effectiveness of the updated

ATTACHMENT A

Quarterly Report Content and Format

comprehensive Quality Strategy as it impacts the demonstration.

Managed Care Reporting Requirements

Address network adequacy reporting from plans including GeoAccess mapping, customer service reporting including average speed of answer at the plans and call abandonment rates; summary of MCO appeals for the quarter including overturn rate and any trends identified; enrollee complaints and grievance reports to determine any trends; and summary analysis of MCO critical incident report which includes, but is not limited to, incidents of abuse, neglect and exploitation. The state must include additional reporting requirements within the annual report as outlined in STC 66(e).

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments

Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s)

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

ATTACHMENT B

Historical Budget Neutrality Data

The table below lists the calculated per-member per-month (PMPM) figures for the Diamond State Health Plan by eligibility group and service, as well as the negotiated trend rates for each of the demonstration years preceding this extension. During the 2006 renewal, the service categories listed below (pharmacy, behavioral health, and managed care) were collapsed into one PMPM per eligibility group.

Note: During DSHP's extension under the authority of section 1115(f), demonstration year eight was converted from the Federal fiscal year to a calendar year. Therefore, an additional three months (noted below as Oct – Dec. 2003) was added to the extension period in order to put the Demonstration on a calendar year basis.

DY	Time Period	Service Category	TANF Children		TANF Adults		SSI Children		SSI Adults	
			Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM
1	FFY 1996	<i>Pharmacy</i>	25.3%	\$ 9.66	32%	\$ 29.08	21%	\$ 51.51	27.4%	\$ 58.95
		<i>Behavioral Health</i>	29.8%	\$ 31.64	29.8%	\$ 1.15	29.8%	\$ 85.17	29.8%	\$ 119.28
		<i>Managed Care</i>	6.79%	\$ 92.60	6.17%	\$ 215.39	6.85%	\$ 647.08	6.85%	\$ 523.85
2	FFY 1997	<i>Pharmacy</i>	6.79%	\$ 10.31	6.17%	\$ 30.87	6.85%	\$ 55.04	6.85%	\$ 169.84
		<i>Behavioral Health</i>	6.79%	\$ 33.79	6.17%	\$ 1.22	6.85%	\$ 85.17	6.85%	\$ 119.28
		<i>Managed Care</i>	6.79%	\$ 98.89	6.17%	\$ 228.67	6.85%	\$ 691.41	6.85%	\$ 559.74
3	FFY 1998	<i>Pharmacy</i>	6.79%	\$ 11.01	6.17%	\$ 32.78	6.85%	\$ 58.81	6.85%	\$ 181.47
		<i>Behavioral Health</i>	6.79%	\$ 36.08	6.17%	\$ 1.29	6.85%	\$ 97.23	6.85%	\$ 136.19
		<i>Managed Care</i>	6.79%	\$ 105.60	6.17%	\$ 242.78	6.85%	\$ 738.77	6.85%	\$ 598.08
4	FFY 1999	<i>Pharmacy</i>	6.79%	\$ 11.76	6.17%	\$ 34.80	6.85%	\$ 62.83	6.85%	\$ 193.90
		<i>Behavioral Health</i>	6.79%	\$ 38.53	6.17%	\$ 1.37	6.85%	\$ 103.89	6.85%	\$ 145.51
		<i>Managed Care</i>	6.79%	\$ 112.77	6.17%	\$ 257.76	6.85%	\$ 789.37	6.85%	\$ 639.05
5	FFY 2000	<i>Pharmacy</i>	6.79%	\$ 12.56	6.17%	\$ 36.95	6.85%	\$ 67.14	6.85%	\$ 207.18
		<i>Behavioral Health</i>	6.79%	\$ 41.15	6.17%	\$ 1.46	6.85%	\$ 111.01	6.85%	\$ 155.48
		<i>Managed Care</i>	6.79%	\$ 120.43	6.17%	\$ 273.67	6.85%	\$ 843.45	6.85%	\$ 682.82
6	FFY 2001	<i>Pharmacy</i>	6.79%	\$ 13.41	6.17%	\$ 39.23	6.85%	\$ 71.74	6.85%	\$ 221.37
		<i>Behavioral Health</i>	6.79%	\$ 43.94	6.17%	\$ 1.55	6.85%	\$ 118.62	6.85%	\$ 166.13
		<i>Managed Care</i>	6.79%	\$ 128.61	6.17%	\$ 290.55	6.85%	\$ 901.22	6.85%	\$ 729.59
7	FFY 2002	<i>Pharmacy</i>	6.79%	\$ 14.32	6.17%	\$ 41.65	6.85%	\$ 76.65	6.85%	\$ 236.54
		<i>Behavioral Health</i>	6.79%	\$ 46.93	6.17%	\$ 1.64	6.85%	\$ 126.74	6.85%	\$ 177.51

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Historical Budget Neutrality Data

		<i>Managed Care</i>	6.79%	\$ 137.34	6.17%	\$ 308.48	6.85%	\$ 962.95	6.85%	\$ 779.57
8	FFY 2003	<i>Pharmacy</i>	6.79%	\$ 15.29	6.17%	\$ 44.22	6.85%	\$ 81.90	6.85%	\$ 236.54
		<i>Behavioral Health</i>	6.79%	\$ 50.11	6.17%	\$ 1.74	6.85%	\$ 135.42	6.85%	\$ 189.67
		<i>Managed Care</i>	6.79%	\$ 146.67	6.17%	\$ 327.51	6.85%	\$ 1,028.92	6.85%	\$ 832.97
	Oct – Dec. 2003	<i>Pharmacy</i>	6.79%	\$ 15.54	6.17%	\$ 44.89	6.85%	\$ 83.27	6.85%	\$ 256.96
		<i>Behavioral Health</i>	6.79%	\$ 50.94	6.17%	\$ 1.77	6.85%	\$ 137.68	6.85%	\$ 192.84
		<i>Managed Care</i>	6.79%	\$ 149.10	6.17%	\$ 332.45	6.85%	\$ 1,046.10	6.85%	\$ 846.88

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Historical Budget Neutrality Data

DY	Time Period	Service Category	TANF Children		TANF Adults		SSI Children		SSI Adults	
			Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM
9	CY 2004	<i>Pharmacy</i>	6.79%	\$ 16.60	6.17%	\$ 47.66	6.85%	\$ 88.97	6.85%	\$ 74.56
		<i>Behavioral Health</i>	6.79%	\$ 54.40	6.17%	\$ 1.88	6.85%	\$ 147.11	6.85%	\$ 206.05
		<i>Managed Care</i>	6.79%	\$ 159.22	6.17%	\$ 352.96	6.85%	\$ 1,117.76	6.85%	\$ 904.89
10	CY 2005	<i>Pharmacy</i>	6.79%	\$ 17.73	6.17%	\$ 50.60	6.85%	\$ 95.07	6.85%	\$ 93.37
		<i>Behavioral Health</i>	6.79%	\$ 58.09	6.17%	\$ 1.99	6.85%	\$ 157.19	6.85%	\$ 220.16
		<i>Managed Care</i>	6.79%	\$ 170.03	6.17%	\$ 374.74	6.85%	\$ 1,194.33	6.85%	\$ 966.88
11	CY 2006	<i>Pharmacy</i>	6.79%	\$ 18.93	6.17%	\$ 53.72	6.85%	\$ 101.58	6.85%	\$ 13.47
		<i>Behavioral Health</i>	6.79%	\$ 62.04	6.17%	\$ 2.11	6.85%	\$ 167.96	6.85%	\$ 235.25
		<i>Managed Care</i>	6.79%	\$ 181.58	6.17%	\$ 397.86	6.85%	\$ 1,276.14	6.85%	\$ 1,033.11
12	CY 2007		5.84%	\$ 280.38	5.16%	\$ 481.68	5.42%	\$ 1,651.56	5.84%	\$ 1,690.19
13	CY 2008		5.84%	\$ 296.75	5.16%	\$ 506.54	5.42%	\$ 1,741.07	5.84%	\$ 1,781.79
14	CY 2009		5.84%	\$ 314.08	5.16%	\$ 532.54	5.42%	\$ 1,835.44	5.84%	\$ 1,878.37
15	CY 2010		5.84%	\$332.40	5.16%	\$560.21	5.20%	\$1,930.89	5.20%	\$1,976.02
16	CY 2011		5.84%	\$351.81	5.16%	\$589.12	5.20%	\$2,031.30	5.20%	\$2,078.77
17	CY 2012		5.84%	\$372.36	5.16%	\$619.52	5.20%	\$2,136.93	5.20%	\$2,186.87

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Historical Budget Neutrality Data

18	CY 2013		5.84%	\$394.11	5.16%	\$651.49	5.20%	\$2,248.05	5.20%	\$2,300.59
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ATTACHMENT C

DSHP-Plus HCBS Service Definitions

<u>HCBS Service</u>	<u>Service Definition</u>
<p>Case Management</p>	<p>Case management includes services assisting participants in gaining access to needed demonstration and other state plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case managers are responsible for the ongoing monitoring of the provision of services included in the participant’s service plan and/or participant health and welfare. Case managers are responsible for initiating the process to evaluate the/or re-evaluate the individual’s level of care and/or the development of service plans. Case managers are responsible for assisting the participant in gaining access to needed services regardless of the funding source.</p> <p>All DSHP-Plus members will receive case management. The case manager provides intensive case management for DSHP-Plus members in need of long term care services through service planning and coordination to identify services; brokering of services to obtain and integrate services, facilitation and advocacy to resolve issues that impede access to needed services; monitoring and reassessment of services based on changes in member’s condition; and gate keeping to assess and determine the need for services to members.</p>
<p>Community-based residential alternatives that include Assisted Living Facilities</p>	<p>Community-based residential services offer a cost-effective, community based alternative to nursing facility care for persons who are elderly and/or adults with physical disabilities. This currently includes assisted care living facilities. Community-based residential services include personal care and supportive services (homemaker, chore, attendant services, and meal preparation) that are furnished to participants who reside in homelike, non-institutional settings. Assisted living includes a 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming, and medication assistance (to the extent permitted under state law). As needed, this service may also include prompting to carry out desired behaviors and/or to curtail inappropriate behaviors. Services that are provided by third parties must be coordinated with the assisted living provider. Personal care services are</p>

ATTACHMENT C

DSHP-Plus HCBS Service Definitions

<u>HCBS Service</u>	<u>Service Definition</u>
	provided in assisted living facilities as part of the community-based residential service. To avoid duplication, personal care (as a separate service) is not available to persons residing in assisted living facilities.
Personal Care/ Attendant Care Services	Personal care includes assistance with ADLs (e.g. bathing, dressing, personal hygiene, transferring, toileting, skin care, eating and assisting with mobility). When specified in the service plan, this service includes assistance with instrumental activities of daily living (IADLs) (e.g. light housekeeping chores, shopping, meal preparation). Assistance with IADLs must be essential to the health and welfare of the participant based on the assessment of the Case Manager and with input from the participant and their family caregivers. This service is not available to persons residing in Assisted Living.
Respite Care	<p>Respite care includes services provided to participants unable to care for themselves furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. FFP is not claimed for the cost of room and board. This is provided both at home and in Nursing and Assisted Living Facilities. This service is limited to no more than fourteen (14) days per year. The managed care organization may authorize service request exceptions above these limits on a case-by-case basis when it determines that:</p> <ul style="list-style-type: none"> • No other service options are available to the member, including services provided through an informal support network; • The absence of the service would present a significant health and welfare risk to the member; and • Respite service provided in a nursing home or assisted living facility is not utilized to replace or relocate an individual’s primary residence.
Adult Day Services	Services furnished in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a “full nutritional regimen” (3 meals per day). Physical, occupational and speech therapies indicated in the individual’s plan of care will be furnished as component

ATTACHMENT C

DSHP-Plus HCBS Service Definitions

<u>HCBS Service</u>	<u>Service Definition</u>
	<p>parts of this service. The service is reimbursed at two levels: the basic rate and the enhanced rate. The enhanced rate is authorized only when staff time is needed to care for participants who demonstrate ongoing behavioral patterns that require additional prompting and/or intervention. Such behaviors include those which might result from an acquired brain injury. The behavior and need for intervention must occur at least weekly. This service is not available to persons residing in Assisted Living.</p> <p>The meals provided as part of this service are only provided when the participant is at the Adult Day Care Center. The cost of such meals is rolled into the Adult Day Care provider's reimbursement rate. The provider does not bill separately for the meal.</p>
Day Habilitation	<p>Day Habilitation includes assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Day habilitation services focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the service plan. In addition, day habilitation services may serve to reinforce skills or lessons taught in other settings. This service is provided to participants who demonstrate a need based on cognitive, social, and/or behavioral deficits such as those that may result from an acquired brain injury. This service is not available to persons residing in Assisted Living.</p>
Cognitive Services	<p>Cognitive Services are necessary for the assessment and treatment of individuals who exhibit cognitive deficits or maladaptive behavior, such as those that are exhibited as a result of a brain injury. This service is not available to persons residing in Assisted Living and Nursing Facilities. Cognitive services are limited to twenty (20) visits per year plus an assessment.</p>

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DSHP-Plus HCBS Service Definitions

<u>HCBS Service</u>	<u>Service Definition</u>
	<p>The managed care organization may authorize service request exceptions above this limit.</p> <p>Cognitive Services include two key components:</p> <ul style="list-style-type: none"> • Multidisciplinary Assessment and consultation to determine the participant’s level of functioning and service needs. This Cognitive Services component includes neuropsychological consultation and assessments, functional assessment and the development and implementation of a structured behavioral intervention plan. • Behavioral Therapies include remediation, programming, counseling and therapeutic services for participants and their families which have the goal of decreasing or modifying the participant’s significant maladaptive behaviors or cognitive disorders that are not covered under the Medicaid State Plan. These services consist of the following elements: Individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under state law.), services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness, individual activity therapies that are not primarily recreational or diversionary, family counseling (the primary purpose of which treatment of the individual’s condition) and diagnostic services.
Personal Emergency Response System	<p>A Personal Emergency Response System (PERS) is an electronic device that enables a waiver participant to secure help in an emergency. As part of the PERS service, a participant may be provided with a portable help button to allow for mobility. The PERS device is connected to the participant’s phone and programmed to signal a response center and/or other forms of assistance once the help button is activated. This service is not available to persons residing in Assisted Living.</p>
Support for Participant Direction	<p>DSHP-Plus members may opt to self-direct their Personal Care/Attendant services. Support for Participant Direction combines two functions: financial management services (FMS) and information and assistance in support of</p>

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DSHP-Plus HCBS Service Definitions

<u>HCBS Service</u>	<u>Service Definition</u>
	<p>participant direction (support brokerage). Providers of Support for Participant Direction carry out activities associated with both components. The Support for Participant Direction service provides assistance to participants who elect to self-direct their personal care services. Participant direction affords DSHP-Plus members the opportunity to have choice and control over how personal care services are provided and who provides the services. Member participation in participant direction is voluntary. Members may participate in or withdraw from participant direction at any time. To the extent possible, the member shall provide his/her personal care provider ten (10) days advance notice regarding his/her intent to withdraw from participant direction. Providers of this service perform various functions to support participants in planning for and carrying out their responsibilities as common-law employers of personal care attendants.</p> <p>(A) Financial Management Services. Financial management services provide assistance to members with managing funds associated with the services elected for self-direction. The following supports are provided</p> <ul style="list-style-type: none"> • Assist participants in verifying personal care attendant’s citizen status • Collect and process personal care attendants’ timesheets • Process payroll, withholding, filing and payment of applicable federal, state, and local employment-related taxes and insurance • Execute and hold Medicaid provider agreements • Receive and disperse funds for the payment of services to personal care attendants <p>(B) Support Brokerage. Support Brokerage service offers the following support:</p> <ul style="list-style-type: none"> • Coordinate with participants to develop, sign, and update individual service plans

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DSHP-Plus HCBS Service Definitions

<u>HCBS Service</u>	<u>Service Definition</u>
	<ul style="list-style-type: none"> • Recruit personal care attendants • Maintain a roster of personal care attendants • Secure background checks on prospective personal care attendants on behalf of participants • Provide information on employer/employee relations • Provide training to participants and personal care attendants • Provide assistance with problem resolution • Maintain participant files • Provide support in arranging for emergency back-up care
Independent Activities of Daily Living (Chore) Services	<p>Chore services constitute housekeeping services that include assistance with shopping, meal preparation, light housekeeping, and laundry. This is an in-home service for frail older persons or adults with physical disabilities. The service assists them to live in their own homes as long as possible. The service must be provided by trained housekeepers. This service is not available to persons residing in Assisted Living.</p>
Nutritional Supports	<p>Nutritional supports for individuals diagnosed with AIDS that are not covered under the state plan. This service is for individuals diagnosed with HRD/AIDS to ensure proper treatment in those experiencing weight loss, wasting, malabsorption and malnutrition. Such oral nutritional supplements are offered as a service to those identified at nutritional risk. This service covers supplements not otherwise covered under the state plan service. This service does not duplicate a service provided under the state plan as an EPSDT service. Prior authorized by CM. Service must be prior authorized by case manager in conjunction with the consultation of a medical professional’s recommendation for service. Standard for assessing the nutritional risk factors:</p> <ul style="list-style-type: none"> • Weighing less than 90% of usual body weight; • Experiencing weight loss over a one to six month period; • Losing more than five pounds within a preceding month; • Serum albumin is less than 3.2 or very high indicating dehydration, difficulty swallowing or chewing, or persistent diarrhea; or

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DSHP-Plus HCBS Service Definitions

<u>HCBS Service</u>	<u>Service Definition</u>
	<ul style="list-style-type: none"> • Wasting syndrome affected by a number of factors including intake, nutrient malabsorption & physiological and metabolic changes.
Specialized Medical Equipment and Supplies	<p>Specialized medical equipment and supplies not covered under the Medicaid State Plan. This service includes: (a) devices, controls, or appliances specified in the plan of care that enable the member to increase his/her ability to perform activities of daily living; (b) devices, controls, or appliances that enable the member to perceive, control, or communicate with the environment in which he/she lives; (c) items 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 under DSHP-Plus 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 member. This service does not duplicate a service provided under the state plan as an EPSDT service.</p>
Minor Home Modifications	<p>Minor home modifications are funded up to \$6,000 per project; \$10,000 per benefit year; and \$20,000 per lifetime. The contractor case manager may authorize service request exceptions above this limit when it determines the expense is cost-effective. This service is not available to persons residing in Assisted Living.</p> <p>Provision and installation of certain home mobility aids (e.g., a wheelchair ramp and modifications directly related to and specifically required for the construction or installation of the ramp, hand rails for interior or exterior stairs or steps, grab bars and other devices) and minor physical adaptations to the interior of a member’s place of residence which are necessary to ensure the health, welfare and safety of the individual, or which increase the member’s mobility and accessibility within the residence, such as widening of doorways or modification of bathroom facilities. Excluded are installation of stairway lifts or elevators and</p>

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DSHP-Plus HCBS Service Definitions

<u>HCBS Service</u>	<u>Service Definition</u>
	<p>those adaptations which are considered to be general maintenance of the residence or which are considered improvements to the residence or which are of general utility and not of direct medical or remedial benefit to the individual, such as installation, repair, replacement or roof, ceiling, walls, or carpet or other flooring; installation, repair, or replacement of heating or cooling units or systems; installation or purchase of air or water purifiers or humidifiers; and installation or repair of driveways, sidewalks, fences, decks, and patios. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.</p>
Home Delivered Meals	<p>Home-delivered meals (up to 1 meal per day). Nutritionally well-balanced meals, other than those provided under Title III C-2 of the Older Americans Act or through SSGB funds, that provide at least one-third but no more than two-thirds of the current daily Recommended Dietary Allowance (as estimated by the Food and Nutrition Board of Sciences – National Research Council) and that will be served in the enrollee’s home. Special diets shall be provided in accordance with the individual Plan of Care when ordered by the enrollee’s physician. These meals are delivered to the participant’s community residence and not to other setting, such as Adult Day Programs or Senior Centers.</p> <p>The contractor must coordinate the delivery of these meals with staff within the Division of Services for Aging & Adults with Physical Disabilities (DSAAPD) that authorize home-bound meals utilizing Title III (Older Americans Act) and Social Service Block Grant (SSBG) funds.</p>

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PROMISE Eligibility Criteria

Medicaid beneficiaries eligible to enroll in the MCO applying for services must be screened by DSAMH using a standardized clinical and functional assessment developed for Delaware and based on national standards.

Individuals eligible for and enrolled in PROMISE may also be enrolled in the DSHP-Plus program if meeting the criteria for both programs unless the PROMISE individual has been identified as a Community Reintegration Support Project (CRISP) individual under the American with Disabilities (ADA) settlement. If the individual is identified as a CRISP individual, the individual will be enrolled in the PROMISE program only and not DSHP-Plus; the enrollee will receive all services necessary for community living from the PROMISE program through CRISP. The CRISP program will not provide any services under the acute care MCO benefit. The PROMISE program will ensure that Medicaid payments are backed out of any state-only capitated payments made for the CRISP program thus ensuring no duplicate payment between CRISP/PROMISE and DSHP-Plus. For individuals in PROMISE and DSHP-Plus, medically necessary PROMISE services will be provided, in addition to any services that the individual is otherwise eligible for in DSHP-Plus if the individual is assessed as needing additional services and the services are outlined on the individual's Recovery Plan. The PROMISE care manager will coordinate with the DSHP-Plus case manager, who will lead the individual's care team.

The Delaware-specific American Society for Addiction Medicine (ASAM) tool integrates the assessment and evaluation of both mental health and SUD conditions into a single document with an algorithm that can be used to determine functional eligibility and is designed to ensure appropriate treatment of individuals based on their medical and functional needs. State Medicaid eligibility staff will review financial criteria to ensure that applicants meet the community financial eligibility criteria.

To be eligible under PROMISE program, individuals must meet one of the targeting criteria and the corresponding functional criteria under the Delaware-specific tool. The following are acceptable combinations for individuals eligible under the demonstration:

- Target criteria A and functional criteria A or C
- Target criteria B and functional criteria B or C

Targeting Criteria

Target Criteria A: An individual must have formally received one of the included Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses that constitute the targeted portion of the State's definition of SPMI, or a diagnosis of post-traumatic stress disorder (PTSD) by a qualified clinician. Diagnoses include the following:

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PROMISE Eligibility Criteria

DSAMH Current SPMI Diagnosis Codes (updated 7/1/2012)			
DSM IV Code	DSM 5 Code	Disorder	DSM IV Category
295.10	295.90	Schizophrenia, Disorganized Type (<i>In DSM 5 Disorganized subtype no longer used</i>)	Psychotic Disorders ¹
295.20	295.90	Schizophrenia, Catatonic Type (<i>In DSM 5 Catatonic subtype no longer used</i>)	Psychotic Disorders
295.30	295.90	Schizophrenia, Paranoid Type (<i>In DSM 5 Paranoid subtype no longer used</i>)	Psychotic Disorders
295.40	295.40	Schizophreniform Disorder	Psychotic Disorders
295.60	295.90	Schizophrenia, Residual Type (<i>In DSM 5 Residual subtype no longer used</i>)	Psychotic Disorders
295.70	295.70	Schizoaffective Disorder	Psychotic Disorders
295.90	295.90	Schizophrenia, Undifferentiated Type (<i>In DSM 5 Undifferentiated subtype no longer used</i>)	Psychotic Disorders
296.30	296.30	Major Depressive Disorder, Recurrent, Unspecified	Mood Disorders ²
296.32	296.32	Major Depressive Disorder, Recurrent, Moderate	Mood Disorders
296.33	296.33	Major Depressive Disorder, Recurrent, Severe Without Psychotic Features (<i>In DSM 5, “Without Psychotic Features” is not a further specifier</i>)	Mood Disorders
296.34	296.34	Major Depressive Disorder, Recurrent, Severe With Psychotic Features (<i>In DSM 5, “With psychotic features” is its own specifier, and, when present, is used instead of Mild, Moderate, or Severe, not in addition to Severe</i>) ³	Mood Disorders
296.40	296.40	Bipolar I Disorder, Most Recent Episode Hypomanic ⁴	Mood Disorders
296.42	296.42	Bipolar I Disorder, Most Recent Episode Manic, Moderate	Mood Disorders
296.43	296.43	Bipolar I Disorder, Most Recent Episode Manic, Severe Without Psychotic Features (<i>In DSM 5, “Without Psychotic Features” is not a further specifier</i>)	Mood Disorders
296.44	296.44	Bipolar I Disorder, Most Recent Episode Manic, Severe With Psychotic Features (<i>In DSM 5, “With psychotic features” is its own specifier, and, when present, is used instead of Mild, Moderate, or Severe, not in addition to Severe</i>) ⁵	Mood Disorders
296.50	296.50	Bipolar I Disorder, Most Recent Episode Depressed, Unspecified	Mood Disorders
296.52	296.52	Bipolar I Disorder, Most Recent Episode Depressed, Moderate	Mood Disorders
296.53	296.53	Bipolar I Disorder, Most Recent Episode Depressed, Severe w/o Psychotic Features (<i>In DSM 5, “Without Psychotic Features” is not a further specifier</i>)	Mood Disorders

¹ In DSM 5, the associated diagnostic category is labeled, “Schizophrenia Spectrum and Other Psychotic Disorders”.

² In DSM 5, mood disorders are broken out into “Depressive Disorders” and “Bipolar and Related Disorders”.

³ The DSM 5 code for Major Depressive Disorder, Recurrent, with Psychotic Features is 296.34.

⁴ In DSM 5 code 296.40 is also used for “Bipolar I Disorder, Current or Most Recent Episode Manic, Unspecified”.

⁵ The DSM 5 code for “Bipolar I Disorder, Current or Most Recent Episode Manic, with Psychotic Features” is 296.44.

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DSAMH Current SPMI Diagnosis Codes (updated 7/1/2012)			
DSM IV Code	DSM 5 Code	Disorder	DSM IV Category
296.54	296.54	Bipolar I Disorder, Most Recent Episode Depressed, Severe w/ Psychotic Features (<i>In DSM 5, “With psychotic features” is its own specifier, and, when present, is used instead of Mild, Moderate, or Severe, not in addition to Severe</i>) ⁶	Mood Disorders
296.60		Bipolar I Disorder, Most Recent Episode Mixed, Unspecified (<i>This Bipolar 1 sub-type was removed from DSM 5</i>)	Mood Disorders
296.62		Bipolar I Disorder, Most Recent Episode Mixed, Moderate (<i>This Bipolar 1 sub-type was removed from DSM 5</i>)	Mood Disorders
296.63		Bipolar I Disorder, Most Recent Episode Mixed, Severe Without Psychotic Features (<i>This Bipolar 1 sub-type was removed from DSM 5</i>)	Mood Disorders
296.64		Bipolar I Disorder, Most Recent Episode Mixed, Severe With Psychotic Features (<i>This Bipolar 1 sub-type was removed from DSM 5</i>)	Mood Disorders
296.70	296.70	Bipolar Disorder, Most Recent Episode Unspecified	Mood Disorders
296.89	296.89	Bipolar II Disorder	Mood Disorders
297.1	297.1	Delusional Disorder	Psychotic Disorders
301.0	301.0	Paranoid Personality Disorder	Personality Disorders
301.20	301.20	Schizoid Personality Disorder	Personality Disorders
301.22	301.22	Schizotypal Personality Disorder	Personality Disorders
301.83	301.83	Borderline Personality Disorder	Personality Disorders
309.81	309.81	Posttraumatic Stress Disorder (PTSD)	Anxiety Disorders ⁷

Target Criteria B: Individuals may also meet other targeted DSM diagnoses. The DSM diagnosis must be among those that are included in the following larger DSM categories (excluding pervasive developmental disorders):

- Mood Disorders:
 - *In DSM 5 “Depressive Disorders” and “Bipolar and Related Disorders” are separated out as diagnostic groupings*
- Anxiety Disorders:

⁶The DSM 5 code for “Bipolar I Disorder, Current or Most Recent Episode Depressed, with Psychotic Features” is 296.54.

⁷In DSM 5, PTSD is moved to another diagnostic category, called “Trauma- and Stressor-Related Disorders”.

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- *DSM 5 includes a separate category, “Obsessive-Compulsive and Related Disorders”*
- *DSM 5 includes a separate category, “Trauma- and Stressor-Related Disorders”*
- Schizophrenia and Other Psychotic Disorders:
 - *In DSM 5 this category is labeled, “Schizophrenia Spectrum and Other Psychotic Disorders”.*
- Dissociative Disorders
- Personality Disorders
- Substance-Related Disorders:
 - *In DSM 5 this category is labeled, “Substance-Related and Addictive Disorders”*

Functioning Criteria

Each person who is screened and thought to be eligible for PROMISE must receive the State-required diagnostic and functional assessment using the Delaware-specific ASAM tool.

Functional Criteria A: If the individual meets Targeting Criteria A, the individual must be assessed with a rating of moderate on at least one of the six Delaware-specific ASAM dimensions. The six dimensions include the following⁸:

1. Acute intoxication and/or withdrawal potential — substance use
2. Biomedical conditions/complications
3. Emotional/behavioral/cognitive conditions or complications (with five sub-dimensions, including suicidality, self-control/impulsivity, dangerousness, self-care, and psychiatric/emotional health)
4. Readiness to change (with two sub-dimensions, including understanding of illness and recovery, and desire to change)
5. Relapse, continued use, continued problem potential
6. Recovery environment (with two sub-dimensions, including recovery environment and interpersonal/social functioning)

Functional Criteria B: If the individual does not meet Targeting Criteria A, but does meet Targeting Criteria B, the individual must be assessed with a rating of severe on at least one of the above six Delaware-specific ASAM dimensions.

Functional Criteria C: An adult who has previously met the above targeting and functional criteria and needs subsequent medical necessary services for stabilization and maintenance. The

⁸ 2nd edition ASAM by Dr. David Mee-Lee et al. at <http://www.asam.org/publications/patient-placement-criteria/ppc-2r>.

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individual continues to need at least one HCBS service for stabilization and maintenance (i.e., at least one PROMISE service described in the below).

Services
Care management
Benefits counseling
Community psychiatric support and treatment
Community-based residential supports, excluding assisted living
Financial coaching
Independent activities of daily living/chore
Individual employment supports
Non-medical transportation
Nursing
Peer support
Personal care
Psychosocial rehabilitation
Respite
Short-term small group supported employment
Community Transition Services

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Level of Care Criteria

I. Critical Events or Incidents

The Managed Care Organizations under the 1115 waiver demonstration are required to develop and implement a critical incident reporting system on sentinel incidents that occur with its members related to the provision of DSHP and DSHP Plus covered services.

Under DSHP Plus, the MCO authorizes services in a variety of settings, including private homes, adult day care centers and licensed long-term care facilities such as nursing facilities and assisted living facilities. In Delaware, responses to critical events depend in large part on the location in which the event takes place. For events which take place in licensed long-term care facilities, Delaware has split the responsibility between two agencies: the Division of Long Term Care Residents Protection (DLTCRP) and the Office of the State Ombudsman (OSO). These agencies are both located within the Department of Health of Social Services (DHSS). Delaware law gives authority to the DLTCRP to respond to and investigate critical events in licensed long term care facilities. The OSO works closely with DLCTRP by responding to other complaints made by or on behalf of residents in licensed long- term care facilities.

Authority is given to DHSS's Adult Protective Services Program (APS) to respond to and investigate critical events made by or on behalf of impaired adults who live outside of licensed facilities. APS operates an after-hours service and provides a contact number to police and first responders. The after-hours contact number is now available to the general public. The Division of Family Services (DFS) within the Department of Services for Children, Youth and Their Families is the designated agency to receive, investigate, and respond to critical incidents of abuse or neglect of children living in the community. DFS operates the toll free Child Abuse and Neglect Report Line number 24 hours a day, seven days a week.

Delaware has established a Home and Community-Based Services Ombudsman within the OSO. The community ombudsman responds to complaints made on or behalf of older persons and adults with physical disabilities who receive community-services; resolves issues with providers and serves as a mediator; provides information to consumers and their family members; advocates a home care consumer's right to appeal home health care services; and performs other advocacy functions.

DLTCRP has statutory authority under Title 29 DE Code; OSO has authority under Title 16 DE Code, APS has authority under Title 31 DE Code and DFS has authority under Title 16 DE Code, § 903 and § 904.

In Delaware, a critical event or incident is referred to as an "incident" under DLTCRP's Investigative Protocol. Under Delaware law, an incident can be defined

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as anything that has a negative outcome on the resident. For APS, critical events or incidents (as defined in Title 31, Chapter 39 §3910) include abuse, mistreatment, exploitation, and neglect. In addition, APS investigates cases of inadequate self-care (self-neglect) and disruptive behavior.

DMMA has outlined the reporting process to the MCOs: what must be reported; to which agency according to incident type; timeframes to report and frequency of reporting. In all cases, the MCOs shall immediately report by telephone all current information received or known about actual or suspected abuse, neglect, or exploitation to DMMA followed in writing, within 8 hours of identifying any incident. Through working with the appropriate agency, facilitated by DMMA, the MCOs shall cooperate in investigating, resolving and documenting actual and suspected incidents. Further, analysis and trending shall be included in the Quality Management programs of the MCOs and DMMA in an effort to address root causes if any.

II. Member Training and Education

The MCO must provide to all its members information concerning protections from abuse, neglect, and exploitation. Processes for providing information concerning protections from abuse, neglect, and exploitation for persons receiving services in long-term care facilities and for persons receiving services are the responsibilities of the MCO.

The MCOs shall educate DSHP and DSHP Plus members, family members, and/or legal representatives as appropriate during the initial assessment. This information shall also be included in the MCO's Member Handbook or on websites and further communicated if requested.

III. Responsibility for Review of and Response to Critical Events or Incidents

1. APS is the designated agency to receive, investigate, and respond to critical incidents of abuse or neglect of adults living in the community.

When the APS social worker substantiates the complaint and determines that the adult is in need of protective services, the APS worker establishes a care plan within 5 days of the home visit. The care plan is developed in conjunction with the members, their families, and/or legal representatives. This information is shared with the MCO staff. The MCO must integrate the goals and objectives of the APS care plan into the DSHP Plus member's care plan, developed by the MCO case manager. When there is a danger of imminent harm, the appropriate victim assistance services are implemented immediately.

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2. The Division of Family Services within the Department of Services for Children, Youth and Their Families is the designated agency to receive, investigate, and respond to critical incidents of abuse or neglect of children living in the community.
3. Per, any person, agency, organization or entity who knows or in good faith suspects child abuse or neglect must make a report to the Division of Family Services.

IV. Quality Oversight and Improvement

The quality oversight structure consists of representatives from DLTCRP, OSO, APS, DMMA and the MCOs. DMMA leads the Quality Improvement Committee but partners with the listed agencies and organizations to track, trend and implement processes to address root causes. This committee shall utilize a combination of guidelines, policies and procedures that are unique to the specific agency (ex.: Professional Regulations, Division of Public Health, the Attorney General's office) as well as guidance informed by Title 16 of the Delaware Code, § 903, relevant sections of the QMS, and the contract with the MCOs.

As a distinct component of the 1115 demonstration Waiver's Quality Improvement Strategy (QMS), the state will comply with all aspects of HCBS assurances and standards for the PROMISE program including oversight by the Medicaid agency. An amendment to the State's QMS to include PROMISE will be submitted within 90 days of demonstration waiver approval.

As a distinct component of the 1115 demonstration Waiver's Quality Improvement Strategy (QMS), the state, on an ongoing basis, identify, address and seek to prevent occurrence of abuse, neglect and exploitation.

For each performance measure/indicator the state uses to assess compliance, the state utilizes data provided by the MCOs to analyze and assess progress toward the performance measure. Each source of data is analyzed statistically/deductively or inductively. Themes are identified or conclusions drawn and recommendations are formulated where appropriate.

Issues that cannot be resolved at the case manager are brought to the attention of the case manager supervisor for further intervention. Problems with service delivery can be brought to the attention of MCO's Quality Improvement Committee (QIC) and DMMA's Quality Initiative Improvement (QII) Task Force for resolution and remediation. As needed, the MCO terminates the contract of a provider whose service provision is inadequate and notifies DMMA of the action.

APS staff members participate in the overall quality management strategy by

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providing feedback to the MCO and DMMA. Staff representatives from DLTCRP and OSO are available to meet with the QIC quarterly and on an as-needed basis.

Lastly, the MCO case managers can refer member concerns about provider agencies to the Division of Public Health (for licensing issues), or to the DMMA SUR Unit (for fraud and billing irregularities).

An individual applying for nursing facility care or home and community-based services through the Diamond State Health Plan Plus program must meet medical eligibility criteria.

Medical Eligibility Determinations

The state's Division of Medicaid & Medical Assistance Pre-Admission Screening (PAS) team completes a level of care (LOC) screening to determine if the applicant requires the level of care LOC provided by the program. An individual must be in need of skilled or intermediate level of care as determined by PAS and as defined below in order to be medically approved for the DSHP-Plus program's enhanced services. During the LOC determination process, the PAS Team obtains a comprehensive medical evaluation of the level of care needed in a facility or the community. Physician orders are required for skilled nursing needs. The medical evaluation must be signed and dated not more than 365 days before the date of referral for the DSHP-Plus program.

Referrals to PAS may come from the family of the applicant as well as other sources.

LOC Criteria with Implementation of DSHP-Plus – With implementation of DSHP-Plus, Delaware revised the nursing facility (NF) LOC definition for individuals entering a nursing facility to reflect that they must need assistance with at least two Activities of Daily Living (ADLs) rather than the previous minimum requirement of assistance with one ADL. There will be no impact on eligibility as a result of this change. Individuals requesting HCBS must be determined by PAS to be “at-risk” of institutionalization by requiring assistance with at least one ADL. Those Medicaid participants already residing in Nursing Facilities as of implementation of DSHP-Plus will be automatically enrolled in the DSHP-Plus program and their nursing facility services will continue to be covered by Medicaid as long as they continue to require assistance with at least one ADL.

“Activity of daily living (ADL)” means a personal or self-care skill performed, with or without the use of assistive devices, on a regular basis that enables the individual to meet basic life needs for food, hygiene, and appearance. The ADL need may look ‘independent’, but assessment will reflect, without supervision and/or assistance, clients’ ability to function and live independently, will be compromised. Assessment will reflect client’s inability to manage their own hydration, nutrition, medication management, mobility and hygiene, as applicable.

Nursing Facility Level of Care– PAS determines that an individual requires an NF LOC when the individual requires assistance with at least two ADLs. This LOC requirement only applies to individuals newly entering a NF. All individuals receiving services in a NF prior to

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implementation of DSHP-Plus will be grandfathered at the LOC requirement of requiring assistance with at least one ADL as long as they continue to require assistance with at least one ADL. In addition, children residing in the community are medically eligible under TEFRA if they are determined to require a NF LOC.

Level of Care for Individuals At-Risk of Institutionalization – PAS determines that an individual meets medical eligibility criteria for home and community based services under the DSHP-Plus program when the individual is at-risk of institutionalization and requires assistance with one ADL. PAS determines that a TEFRA-like child meets medical eligibility criteria for State plan services when the individual requires assistance with one ADL.

Acute Hospital Level of Care – An Acute Hospital LOC is assigned to individuals that require the highest intensity of medical and nursing services provided within a structured environment providing 24-hour skilled nursing and medical care. Individuals with HIV/AIDS may be determined to require a Hospital LOC when they reside in the community without supportive services and are potentially at high risk for in-patient hospital care. In addition, children residing in the community are medically eligible under TEFRA if they are determined to require a hospital LOC. Such children require the highest intensity of medical and nursing services and, as a result, are potentially at high risk for in-patient hospital care.

Pre-Admissions Screening and Resident Reviews (PASRR)

By federal mandate, all individuals applying for placement in a Medicaid certified nursing facility, regardless of payment source, must have a Level I Pre-Admission Screening and Resident Review (PASRR) for Mental Illness (MI) or Intellectual Disability/Related Condition (MR/RC).

Based on results of a Level I PASRR Screening, the PAS RN may determine that further screening, a Level II PASRR, is warranted. A Level II PASRR evaluates clients with MI and MR/RC and determines if nursing home placement, either with or without specialized services, is appropriate. In addition to the PAS RN, an Independent Contracted Psychiatrist also makes placement recommendations. However, the final decision on appropriate placement for individuals with MI or MR/RC is made by the State Mental Health Authority for MI or the Division of Developmental Disabilities Services for MR/RC.

- **A Level I PASRR Screening is completed on all residents or potential residents of a Medicaid certified Nursing home.**

A Level I screening is the process of identifying individuals who are suspected of having a mental illness or an intellectual disability or related condition. The Nursing Facility is responsible for completing the Level I screening for non-Medicaid individuals. The Division of Medicaid and Medical Assistance is responsible for completing the Level I screening for Medicaid and potential Medicaid individuals when notified.

- **Determination is made regarding the need for a Level II PASRR screening.**
No further evaluation is needed, if, based on the Level I screening, the individual will

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Level of Care Criteria

meet one of three categories:

- No indication of mental illness/mental retardation/related condition – nursing home admission/continued stay is appropriate - No further evaluation is needed.
- There are indicators of mental illness/mental retardation/related condition however individual meets any of the following Physician's Exemption Criteria:
 - Primary Diagnosis of Dementia or related disorder.
 - Convalescent Care not to exceed 30 days - PAS nurses will track this exemption and initiate Level II PASRR evaluation prior to expiration if continued NF stay is warranted.
 - Terminal Illness – a life expectancy of 6 months or less if the illness runs its normal course.
 - Medical dependency with a severe physical illness.

A Level II PASRR Assessment must be completed when the Level I screen reveals indicators of mental illness, intellectual or developmental disabilities.

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PROMISE Service Definitions

HCBS Service	Service Definition
Care management (CM)	<p>CM includes services assisting beneficiaries in gaining access to needed demonstration and other State Plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Care managers are responsible for the ongoing monitoring of the provision of services included in the beneficiary's Recovery Plan and/or beneficiary health and welfare. Care managers are responsible for initiating the process to evaluate and/or re-evaluate the beneficiary's level of care/needs-based eligibility and/or development of Recovery Plans. Care managers are responsible for assisting the beneficiary in gaining access to needed services regardless of the funding source.</p> <p>The care manager provides intensive CM for PROMISE members in need of supports services through service planning and coordination to identify services; brokering of services to obtain and integrate services, facilitation, and advocacy to resolve issues that impede access to needed services; monitoring and reassessment of services based on changes in member's condition; and gate keeping to assess and determine the need for services to members.</p> <p>In the performance of providing information to beneficiaries, the care manager will:</p> <ul style="list-style-type: none">• Inform beneficiaries about the HCBS, required needs assessments, the person-centered planning process, service alternatives, service delivery options (opportunities for beneficiary-direction), roles, rights, risks, and responsibilities.• Inform beneficiaries on fair hearing rights and assist with fair hearing requests when needed and upon request. <p>In the performance of facilitating access to needed services and supports, the care manager will:</p> <ul style="list-style-type: none">• Collect additional necessary information including, at a minimum, beneficiary preferences, strengths, and goals to inform the development of the beneficiary-centered Recovery Plan.• Assist the beneficiary and his/her service planning team in identifying and choosing willing and qualified providers.• Coordinate efforts and prompt the beneficiary to ensure the completion of activities necessary to maintain HCBS program eligibility. <p>In the performance of the coordinating function, the care manager will:</p> <ul style="list-style-type: none">• Coordinate efforts in accordance with department requirements and prompt the beneficiary to participate in the completion of a needs assessment as required by the State to identify appropriate levels of need and to serve as the foundation for the development of and updates to the Recovery Plan.• Use a person-centered planning approach and a team process which may include peer care managers to develop the beneficiary's Recovery Plan to meet the beneficiary's needs in the least restrictive manner possible. At a minimum, the approach shall:<ul style="list-style-type: none">○ Include people chosen by the beneficiary for Recovery Plan meetings, review assessments, include discussion of needs, to gain understanding of the beneficiary's preferences, suggestions for services, and other activities key to ensure a beneficiary-centered Recovery Plan.○ Provide necessary information and support to ensure that the beneficiary directs the process to the maximum extent possible and is enabled to make informed choices and decisions.○ Be timely and occur at times and locations of convenience to the beneficiary; reflect cultural considerations of the beneficiary.○ Include strategies for solving conflict or disagreement within the process.○ Offer choices to the beneficiary regarding the services and supports they receive and the providers who may render them.○ Inform beneficiaries of the method to request updates to the Recovery Plan.

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PROMISE Service Definitions

HCBS Service	Service Definition
CM (cont'd)	<ul style="list-style-type: none">○ Ensure and document the beneficiary's participation in the development of the Recovery Plan.● Develop and update the Recovery Plan in accordance with the State requirements based upon the standardized needs assessment and person-centered planning process annually, or more frequently as needed.● Explore coverage of services to address beneficiary identified needs through other sources, including services provided under the State Plan, Medicare, and/or private insurance or other community resources. These resources shall be used until the plan limitations have been reached or a determination of non-coverage has been established and prior to any service's inclusion in the Recovery Plan, in accordance with department standards.● Actively coordinate with other individuals and/or entities essential in the physical and/or behavioral care delivery for the beneficiary, including MCO care coordinators, to ensure seamless coordination between physical, behavioral, and support services.● Coordinate with providers and potential providers of services to ensure seamless service access and delivery.● Coordinate with the beneficiary's family, friends, and other community members to cultivate the beneficiary's natural support network, to the extent that the beneficiary (adult) has provided permission for such coordination. <p>In the performance of the monitoring function, the care manager will:</p> <ul style="list-style-type: none">● Monitor the health, welfare, and safety of the beneficiary and Recovery Plan implementation through regular contacts (monitoring visits with the beneficiary, paid and unpaid caregivers, and others) at a minimum frequency as required by the department.● Respond to and assess emergency situations and incidents and assure that appropriate actions are taken to protect the health, welfare, and safety of the beneficiary.● Review provider documentation of service provision and monitor beneficiary progress on outcomes and initiate Recovery Plan team discussions or meetings when services are not achieving desired outcomes. Outcomes include housing status, employment status, involvement in the criminal justice system, response to treatment, and other services, and satisfaction with services.● Through the Recovery Plan monitoring process, solicit input from beneficiary and/or family, as appropriate, related to satisfaction with services.● Arrange for modifications in services and service delivery, as necessary, to address the needs of the beneficiary, consistent with an assessment of need and department requirements, and modify the Recovery Plan accordingly.● Advocate for continuity of services, system flexibility and integration, proper utilization of facilities and resources, accessibility and beneficiary rights.● Participate in any department identified activities related to quality oversight. <p>The maximum caseload for a care manager providing services through this waiver is set by Medicaid or its designee, which includes individuals in other waiver programs and other funding sources, unless the requirement is waived by the department.</p> <p>CM agencies must use an information system as approved and required by the department to maintain case records in accordance with department requirements.</p>

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PROMISE Service Definitions

HCBS Service	Service Definition
Benefits Counseling	<p>Benefits Counseling provides work incentive counseling services to PROMISE participants seeking to work while maintaining access to necessary healthcare and other benefits. Benefits counseling will provide information to individuals regarding available benefits and assist individuals to understand options for making an informed choice about going to work while maintaining essential benefits. This service will assist individuals to understand the work incentives and support programs available and the impact of work activity on those benefits. This service will assist individuals to understand their benefits supports and how to utilize work incentives and other tools to assist them to achieve self-sufficiency through work. This service will also include the development and maintenance of proper documentation of services, including creating Benefits Summaries and Analyses and Work Incentive Plans. Services must be delivered in a manner that supports the participant's communication needs including, but not limited to, age appropriate communication, translation/interpretation services for participants that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding and use of communication devices used by the participant.</p>
Community psychiatric support and treatment (CPST)	<p>CPST services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid eligible adults with significant functional impairments meeting the need levels in the PROMISE program resulting from an identified mental health or substance abuse disorder diagnosis. The medical necessity for these treatment and rehabilitative services must be determined by a licensed behavioral health practitioner (LBHP) or physician who is acting within the scope of his/her professional license and applicable state law and furnished by or under the direction of a licensed practitioner, to promote the maximum reduction of symptoms and/or restoration of a beneficiary to his/her best age-appropriate functional level. The LBHP or physician may conduct an assessment consistent with state law, regulation, and policy. A unit of service is defined according to the healthcare common procedure coding system (HCPCS) approved code set unless otherwise specified.</p> <p>Definitions:</p> <p>The services are defined as follows:</p> <ul style="list-style-type: none">• CPST are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the beneficiary's Recovery Plan. CPST is a face-to-face intervention with the beneficiary present; however, family or other collaterals may also be involved. This service may include the following components:<ul style="list-style-type: none">○ Assist the beneficiary and family members or other collaterals to identify strategies or treatment options associated with the beneficiary's mental illness and/or SUD, with the goal of minimizing the negative effects of symptoms or emotional disturbances or associated environmental stressors which interfere with the beneficiary's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.○ Provide beneficiary supportive counseling, solution-focused interventions, emotional and behavioral management support, and behavioral analysis with the beneficiary, with the goal of assisting the beneficiary with developing and implementing social, interpersonal, self-care, daily living, and independent living skills to restore stability, to support functional gains, and to adapt to community living.○ Facilitate participation in and utilization of strengths-based planning and treatments, which include assisting the beneficiary and family members or other collaterals with identifying strengths and needs, resources, natural supports, and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their mental illness and/or SUD.

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PROMISE Service Definitions

HCBS Service	Service Definition
CPST (cont'd)	<ul style="list-style-type: none"> ○ Assist the beneficiary with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the beneficiary and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or as appropriate, seeking other supports to restore stability and functioning. ○ Provide restoration, rehabilitation, and support to develop skills to locate, rent, and keep a home, to enable landlord/tenant negotiations; to select a roommate and to understand and exercise renter's rights and responsibilities. ○ Assist the beneficiary to develop daily living skills specific to managing their own home including managing their money, medications, and using community resources and other self-care requirements. ○ Implement interventions using evidence-based techniques, drawn from cognitive-behavioral therapy and other evidence-based psychotherapeutic interventions that ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom manifestation.
Community-based residential alternatives supports that exclude assisted living	<p>Community-based residential supports (excluding assisted living) offer a cost-effective, community-based alternative to institutional levels of care for persons with BH needs. Community-based residential services are supportive and health-related residential services provided to beneficiaries in settings licensed by the State. Residential services are necessary, as specified in the Recovery Plan, to enable the beneficiary to remain integrated in the community and ensure the health, welfare, and safety of the beneficiary. Community-based residential services include personal care and supportive services (homemaker, chore, attendant services, and meal preparation) that are furnished to beneficiaries who reside in homelike, non-institutional, integrated settings. In addition, they include 24-hour onsite response capability to meet scheduled and unscheduled or unpredictable beneficiary needs to provide supervision and safety. Services also include social and recreational programming, and medication assistance (to the extent permitted under State law).</p> <p>This service includes assisting beneficiaries in acquiring, retaining, and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside successfully in home and community-based settings. As needed, this service may also include prompting to carry out desired behaviors and/or to curtail inappropriate behaviors as well as habilitative services to instruct beneficiaries in accessing and using community resources such as transportation, translation, and communication assistance related to a habilitative outcome and services to assist the beneficiary in shopping and other necessary activities of community and civic life, including self advocacy. Finally, assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) are included. This service will be provided to meet the beneficiary's needs as determined by an assessment performed in accordance with department requirements and as outlined in the beneficiary's Recovery Plan.</p> <p>ADLs include tasks related to caring for and moving the body. ADLs include:</p> <ul style="list-style-type: none"> ● Walking. ● Bathing. ● Dressing. ● Toileting. ● Brushing teeth. ● Eating.

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PROMISE Service Definitions

Community-based residential alternatives supports that exclude assisted living (cont'd)

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

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

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

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

The cost of transportation provided by residential service providers to and from activities is included as a component of the residential services and; therefore, is reflected in the rate for the service.

Providers of residential services are responsible for the full range of transportation services needed by the beneficiaries they serve to participate in services and activities specified in their Recovery Plan.

This includes transportation to and from daily activities and employment services, as applicable.

The service provider must maintain documentation in accordance with department requirements. The documentation must be available to the care manager for monitoring at all times on an ongoing basis. The care manager will review the authorized tier on an ongoing basis and monitor the community character of the residence during regularly scheduled contact with the beneficiary. Results of this monitoring will be reported to the department. If the monitoring suggests that a change in tiers is needed, the care manager will recommend a re-assessment to re-evaluate the beneficiary to determine the appropriateness of the assigned tier in accordance with department requirements.

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

Model 1 — habilitative supports in the home (the beneficiary is encouraged to seek BH treatment for SPMI in the community) (Tiers 1 and 2).

Tier 1: A beneficiary requires:

- Limited supervision as the beneficiary is able to make safe decisions when in familiar surroundings, but requires occasional increased need for assistance or to address unanticipated needs, with supports available on a 24-hour on call or as-needed basis, AND
 - Incidental or intermittent hands-on assistance or cueing for at least one ADL and at least one IADL, OR
 - Incidental or intermittent hands-on assistance or cueing with at least three IADLs, OR
 - Instruction in accessing and using community resources, such as transportation, translation, and communication assistance related to a habilitative outcome and services to assist the beneficiary
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PROMISE Service Definitions

HCBS Service	Service Definition
	in shopping and other necessary activities of community and civic life, including self-advocacy. Instruction in developing or maintaining financial stability and security (e.g., understanding budgets, managing money, and the right to manage their own money).

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PROMISE Service Definitions

Community-based residential alternatives supports that exclude assisted living (cont'd)

Tier 2: A beneficiary requires:

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

Model 2 — intensive supports for medically fragile beneficiaries (Tiers 3 and 4).

Tier 3: A beneficiary requires:

- Supervision with staff on site to ensure safety from harm as determined by an assessment.
- Intermittent skilled care of a licensed professional or paraprofessional throughout the day for medical diagnosis or medical treatment.
- Management of one or more behaviors of a disruptive or destructive nature that prevent or interfere with the beneficiary's inclusion in home and family life or community life.
- Hands-on assistance or cueing with at least two ADLs or periodic assistance throughout a day with at least three ADLs.
- Complete assistance with at least four IADLs.

Special care unit services.

Tier 4: A beneficiary requires:

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

Medical Necessity criteria for Tier4 includes meeting the following:

ASAM Criteria

Can have high immediate need profile

1. Substance abuse — can have current potential (fifth choice)
2. Biomed — up to “current/unstable”
3. Suicidality — any level not needing acute

3. *Suicidality* – control/impulsivity — has moderate- high risk for problems

3. *Dangerousness* — highest risk that does not require inpatient

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

3. *Psychological/ emotional health* — any level or

4. Readiness to change — any level or

5. Relapse, etc. — any level (except for those in 3–5 day beds, which will probably have high need on 3 and on 5)

Community Living Questionnaire

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

ASAM, along with collaterals/health record, are important for determining Tier 4

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PROMISE Service Definitions

HCBS Service	Service Definition
Financial coaching	<p data-bbox="446 289 1555 598">Financial Coaching Plus uses a financial coaching model to assist individuals in establishing financial goals, creating a plan to achieve them, and providing information, support, and resources needed to implement stated goals in the financial plan. The financial coach will assist the client seeking to improve his/her financial situation in order to improve economic self-sufficiency. Financial Coaching Plus includes the development of a personal budget and identifies reliable and trusted savings, credit, and debt programs that promote financial stability. The content and direction of the coaching is customized to respond to the individual financial goals set by the participant. Financial coaching is provided to the client one-on-one in a setting convenient for the client over a time-limited series of sessions and follow-up to increase the opportunity for self-directed behavior skills learning. The Financial Coach will:</p> <ul data-bbox="446 604 1555 1081" style="list-style-type: none">• Assist the client in developing financial strategies to reach participant’s goals with care to ensure that personal strategies reflect considerations related to benefits, as identified through benefits counseling;• Ensure that individuals understand the availability of various tax credits such as the Earned Income Tax Credit, Child Care Tax Credit, and others;• Refer individuals as needed to benefit counselors;• Provide information to complement information provided through benefits counseling regarding appropriate asset building;• Use an integrated dashboard of available community-based asset building opportunities and financial tools/services to ensure participants are leveraging all resources to increase economic self-sufficiency;• Provide information about how to protect personal identify and avoid predatory lending schemes;• Provide assistance with filing yearly taxes either through the IRS VITA program or its virtual program that involves self-filing. <p data-bbox="446 1087 1555 1291">The Financial Coaching Plus service will include the collection and maintenance of proper documentation of services provided as required by the Department that will track goals, actions, and outcomes of individual participants. The Financial Coaching Plus service may complement information provided on the use of public benefits and/or work incentives through Benefits Counseling or other services. Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.) or other services</p>

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PROMISE Service Definitions

HCBS Service	Service Definition
IADL/chore	<p>IADL/chore services are delivered to beneficiaries that reside in a private home and are necessary, as specified in the Recovery Plan, to enable the beneficiary to integrate more fully into the community and to ensure the health, welfare, and safety of the beneficiary.</p> <p>This service will be provided to meet the beneficiary’s needs, as determined by an assessment performed in accordance with department requirements and as outlined in the beneficiary’s Recovery Plan.</p> <p>IADL services consist of the performance of general household tasks (e.g., meal preparation, cleaning, laundry, and other routine household care) provided by a qualified homemaker when the beneficiary regularly responsible for these activities is absent or unable to manage the home and care for him or herself or others in the home, or when no landlord or provider agency staff is responsible to perform the IADL services.</p> <p>Chore services consist of services provided to maintain the home in a clean, sanitary, and safe condition. This service includes heavy household chores, such as:</p> <ul style="list-style-type: none">• Washing floors, windows, and walls.• Tacking down loose rugs and tiles.• Moving heavy items of furniture in order to provide safe access and egress.• Removing ice, snow and/or leaves.• Yard maintenance. <p>The providers of this service must review and be familiar with the crisis support plan. IADL/chore services may not be billed at the same time as personal care or respite services.</p> <p>IADL/chore services are limited to 40 hours per beneficiary per service plan Recovery Plan year when the beneficiary or family member(s) or friend(s) with whom the beneficiary resides is temporarily unable to perform and financially provide for the IADL/chore functions.</p>
Individual employment support services (IESS)	<p>IESS are services to beneficiaries needing on-going individualized support to learn a new job or to maintain a job in a competitive or customized integrated work setting that meets job and career goals (including self-employment). Beneficiaries in a competitive employment arrangement receiving IESS are compensated at or above the minimum wage and receive similar wages and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. IESS are necessary, as specified in the Recovery Plan, to support the beneficiary to live and work successfully in home and community-based settings, enable the beneficiary to integrate more fully into the community and ensure the health, welfare, and safety of the beneficiary.</p>

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PROMISE Service Definitions

Supported beneficiary 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: on-going vocational/job-related discovery or assessment not otherwise covered in the annual career planning, on-going person-centered employment planning not otherwise covered in the annual career planning, job placement, job development negotiation with prospective employers, job analysis, job carving, training and systematic instruction, individual supports, benefits support, training, planning, transportation, asset development and career advancement services, implementation of assistive technology, and other workforce support services including services not specifically related to job skill training that enable the waiver beneficiary to be successful in integrating into the job setting. Supported employment includes person-centered, comprehensive employment planning and support services that provide assistance for waiver program beneficiaries to obtain, maintain, or advance in competitive employment or self-employment. This employment planning includes engaging a beneficiary in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state's minimum wage. The outcome of this activity is identification of the beneficiary's stated career objective and development of a career plan used to guide beneficiary employment support in competitive employment.

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

Supported employment may provide work experiences where the beneficiary can develop strengths and skills that contribute to employability in paid employment in integrated community settings. IESS include supervision, monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills and training and education in self-determination.

Skills development as a part of placement and training may occur as a one-to-one training experience in accordance with department requirements. IESS may be utilized for a beneficiary to gain work related experience considered crucial for job placement (e.g., unpaid internship), if such experience is vital to the person achieve his or her vocational goal. Provide and support the acquisition of skills necessary to enable the beneficiary to obtain competitive, integrated work where the compensation for the beneficiary is at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities, which is considered to be the optimal outcome of IESS.

In addition to the elements note above, IESS provides two components in accordance with an assessment: intensive IESS and extended follow-along.

Intensive IESS is an essential component of individual employment support services and may include:

- On the job training and skills development.
 - Assisting the beneficiary with development of natural supports in the workplace.
 - Helping the beneficiary to attend school and providing academic supports, when that is their preference.
 - Coordinating with employers or employees, coworkers and customers, as necessary. (Note: Coordinating with employers and other employees is done only if the beneficiary prefers to have her or his mental illness disclosed and gives permission. Supporting the beneficiary's preference in this area is fundamental to recovery.)
 - Providing work incentives planning prior to or during the process of job placement. Work incentives planning involves helping the beneficiary review her or his options for working (number of hours per week, etc.), given the hourly pay the beneficiary is being offered, or is likely to be offered, the beneficiary's current income needs, and the rules concerning how Social Security Administration benefits, medical benefits, medical subsidies, and other subsidies
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PROMISE Service Definitions

HCBS Service	Service Definition
	<p>(housing, food stamps, etc.) change based on income from paid employment. (This includes providing information on Ticket to Work, etc.). Work incentives planning allows beneficiaries to make informed decisions about how many hours per week to work, as well as their preferred timing in moving from part-time to full-time work. Beneficiaries also are given information and assistance about reporting earnings to various sources of entitlements/benefits.</p> <ul style="list-style-type: none">• Assisting beneficiaries in making informed decisions about whether to disclose their mental illness condition to employers and co-workers.• Intensive IESS includes assisting the beneficiary in meeting employment expectations, performing business functions, addressing issues as they arise, and also includes travel training, and diversity training to the specific business where the beneficiary is employed. Intensive IESS provides support to assist beneficiaries in stabilizing in an integrated situation (including self-employment) and may include activities on behalf of the beneficiary when the beneficiary is not present to assist in maintaining job placement. Once the beneficiary is stable in the position, extended follow along will ensue. <p>Extended follow-along is ongoing support available for an indefinite period as needed by the beneficiary to maintain their paid employment position once they have been stabilized in their position (generally receiving onsite support once per month or less). Extended follow-along support may include reminders of effective workplace practices and reinforcement of skills gained during the period of intensive IESS.</p>
Non-medical transportation	<p>Non-medical transportation services are offered, in addition to any medical transportation furnished under the 42 CFR 440.17(a) in the State Plan. Non-medical transportation services are necessary, as specified by the Recovery Plan, to enable beneficiaries to gain access to waiver services that enable them to integrate more fully into the community and ensure the health, welfare, and safety of the beneficiary. In order to be approved, non-medical transportation would need to be directly related to a goal on the beneficiary's treatment plan (e.g., to a supported employment job) and not for the general transportation needs of the client (e.g., regular trips to the grocery store). This service will be provided to meet the beneficiary's needs as determined by an assessment performed in accordance with department requirements and as specifically outlined in the beneficiary's Recovery Plan.</p> <p>Transportation services consist of:</p> <ul style="list-style-type: none">• Transportation (mile): This transportation service is delivered by providers, family members, and other qualified, licensed drivers. Transportation (mile) is used to reimburse the owner of the vehicle or other qualified, licensed driver who transports the beneficiary to and from services and resources related to outcomes specified in the beneficiary's Recovery Plan. The unit of service is one mile. Mileage can be paid round trip. A round trip is defined as from the point of first pickup to the service destination and the return distance to the point of origin. When transportation (mile) is provided to more than one beneficiary at a time, the provider will divide the shared miles equitably among the beneficiaries to whom transportation is provided. The provider is required (or it is the legal employer's responsibility under the Vendor Fiscal/Employer Agent model) to track mileage, allocate a portion to each beneficiary, and provide that information to the care manager for inclusion in the beneficiary's Recovery Plan.• Public transportation: The utilization of public transportation promotes self-determination and is made available to beneficiaries as a cost-effective means of accessing services and activities. This service provides payment for the beneficiary's use of public transportation. <p>The care manager will monitor this service quarterly and will provide ongoing assistance to the beneficiary to identify alternative community-based sources of transportation.</p>
Nursing	<p>Nursing services are prescribed by a physician in addition to any services under the State Plan as determined by an assessment in accordance with department requirements. Nursing services are necessary, as specified in the Recovery Plan, to enable the beneficiary to integrate more fully into the community and ensure the health, welfare, and safety of the beneficiary. This service is intended to be utilized in the beneficiary's home.</p>

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PROMISE Service Definitions

HCBS Service	Service Definition
	<p>Services are provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse licensed to practice in the State. The physician's order to reauthorize must be obtained every ninety (90) days for continuation of service. If changes in the beneficiary's status take place after the physician's order, but prior to the reauthorization of the service, and result in a change in the level of services authorized in the Recovery Plan, the provider is responsible for reporting to the ordering physician and care manager.</p> <p>Nursing services must be performed by a registered nurse or licensed practical nurse as defined by the State Nurse Practice Act. Skilled nursing is typically provided on a one to one basis and can be continuous, intermittent, or short-term, based on the beneficiary's assessed need.</p> <ul style="list-style-type: none">• Short-term or intermittent nursing: Nursing that is provided on a short-term or intermittent basis, not expected to exceed 75 units of service in a Recovery Plan year and are over and above services available to the beneficiary through the State Plan.• Long-term or continuous nursing: Long-term or continuous nursing is needed to meet ongoing assessed needs that are likely to require services in excess of 75 units per Recovery Plan year, are provided on a regular basis and are over and above services available to the beneficiary through the State Plan. Services must be delivered in a manner that supports the beneficiary's communication needs including, but not limited to age appropriate communication, translation services for beneficiary's that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding and use of communication devices used by the beneficiary.• The nursing service provider must maintain documentation in accordance with department requirements. The documentation must be available to the care manager for monitoring at all times on an ongoing basis. The care manager will monitor on a quarterly basis to see if the objectives and outcomes are being met.

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PROMISE Service Definitions

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

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PROMISE Service Definitions

HCBS Service	Service Definition
PS (cont'd)	<p>A certified peer/recovery coach would be a beneficiary who has self-identified as a beneficiary or survivor of mental health or SUD services and meets the qualifications set by the State including specialized training, to be considered in accordance with State standards, certification, and registration. The training provided/contracted by DSAMH shall be focused on the principles and concepts of PS and how it differs from clinical support. It will also provide practical tools for promoting wellness and recovery, knowledge about beneficiary rights and advocacy, as well as approaches to care that incorporate creativity. To qualify for peer certification training a peer/recovery coach must self-identify as a person with a lived experience of mental illness and/or substance abuse, be at least 21 years of age, have at minimum a high school education or General Education Development certificate, (preferably with some college background) and be currently employed as a peer supporter in Delaware. It is required that peers/recovery coaches must complete Delaware State-approved standardized peer specialist training that includes academic information as well as practical knowledge and creative activities.</p> <p>A peer/recovery coach uses lived experience with a mental illness, SUD, or another co-occurring disorder such as PH, developmental disability, etc. or assist in supporting beneficiaries in their recovery path.</p> <p>This service may include the following components:</p> <ul style="list-style-type: none">• Helps beneficiaries aspire to and attain roles which emphasize their strengths by:<ul style="list-style-type: none">○ Sharing parts of their own personal recovery story and first hand experiences. Providing mutual support, hope, reassurance, and advocacy.○ Provides PS to beneficiaries regarding understanding their symptoms of mental illness and effects of trauma and trauma history, developing positive coping skills.○ Engaging beneficiaries through outreach and support.○ Assists beneficiaries to advocate for self and others.○ Promotes recovery through modeling by:<ul style="list-style-type: none">▪ Sharing one's own personal recovery story.

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- Display of self-confidence and self-determination.
- Use of natural supports including connections to friends and family, peer mutual help groups, and other supports in the community.
- Display of personal achievements of personal recovery goals.
- Helps the beneficiary to develop a network for information and support from others who have been through similar experiences.
- Assists the beneficiary with gaining and regaining the ability to make independent choices and to take a proactive role in treatment, including discussing questions or concerns about medications, diagnoses or treatment approaches with their treating clinician.
- Assists the beneficiary with identifying and effectively responding to or avoiding identified precursors or triggers that result in functional impairments.
- Assists the beneficiary to complete peer-related elements of a comprehensive assessment.
- Prepares the beneficiary to attend their recovery plan meetings and is present to assist them express their goals and needs.
- Assists beneficiary to accomplish their life goals of living in a chosen community, including working in a job and engaging in activities, including leisure activities, to support community integration, having a natural support system in place, and having a number of hobbies or activities that are creative and integrated community leisure activities.
- Works with the beneficiary and staff in developing and implementing person-directed beneficiary recovery plans, using both their own expertise, based on their lived experience, as well as evidence-based tools, such as Wellness Recovery Action Planning.
- Assists in helping the beneficiary to work on their beneficiary wellness plan for physical and emotional wellness. These services might include physical exercise, dietary assistance, recognition of medical/healthcare needs, introduction to alternative healing techniques such as meditation or massage, etc. PS specialists are primarily expected to engage beneficiaries and provide personalized individualized support toward recovery. However, PS specialists may assist with IADLs, when they are assessed to be important aspects of the recovery process for a person to whom the PS specialist is providing services, consistent with the broader PS role.
- Facilitates peer recovery support groups. Accompanies beneficiaries to appointments which connect them to community resources and services. Under this service, the peer staff should not provide transportation. If the peer provides non-medical transportation, the peer should be enrolled as a transportation provider and separately charge for the non-medical transportation service instead of peer support. Peers should not be routinely used to provide client transportation.
- Acts as an advocate for beneficiaries to secure needed services, financial entitlements, and effectively raise complaints and suggestions about unmet needs, and helps beneficiaries develop self-advocacy skills.
- Locates peer-run programs and support groups for interested beneficiaries.
- Participates in the ongoing engagement of beneficiaries.

A peer specialist/recovery coach should ensure that the following occur:

- Maintains compliance with all applicable practice standards and guidelines.
- Maintains beneficiary confidentiality and adherence to Health Insurance Portability & Accountability Act requirement at all times.
- Completes all required documentation in a timely manner consistent with agency guidelines.
- Maintains agency required productivity standards.

Peer specialists/recovery coaches may function within a team or work with the beneficiary on a beneficiary basis. Peer specialists/recovery coaches may serve on ACT and ICM teams. If the PS functions within a team, then the peer/recovery coach:

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	<ul style="list-style-type: none">• Provides training and education to the beneficiary and other members of the beneficiary’s team on:<ul style="list-style-type: none">○ Recovery-oriented care and processes.○ Local and national PS resources and advocacy organizations.○ Psychiatric advance directives: advocacy, information, and referral.○ Recovery planning, illness self-management, and wellness tools.○ Trauma informed care.○ Use of expressive therapies.<ul style="list-style-type: none">▪ Is not used primarily to complete tasks that clinicians or other specialists on the team do not want to complete, such as transport beneficiaries, complete paper work, and so on.
Personal Care	<p>Personal care includes care with ADLs (e.g., bathing, dressing, personal hygiene, transferring, toileting, skin care, eating, and assisting with mobility). When specified in the Recovery Plan, this service includes care with IADLs (e.g., light housekeeping, chores, shopping, meal preparation). Care with IADLs must be essential to the health and welfare of the beneficiary based on the assessment of the care manager and identified within the Recovery Plan as a goal that was identified by the beneficiary. Input should also be obtained from the beneficiaries’ family or other natural supports, when appropriate and desired by the beneficiary.</p> <p>Personal care services primarily provide hands-on care to beneficiaries that reside in a private home and that are necessary, as specified in the Recovery Plan, to enable the beneficiary to integrate more fully into the community and ensure the health, welfare, and safety of the beneficiary.</p> <p>This service will be provided to meet the beneficiary’s needs, as determined by an assessment, in accordance with department requirements and as outlined in the beneficiary’s Recovery Plan.</p> <p>The provider and beneficiary will be encouraged to hire staff to deliver personal care services separate from staff who provide habilitation services that involved the development of ADL and IADL skills, if there is more than one staff member on site at the residence during normal hours who can provide</p>

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	<p>personal care services. This will ensure that the clinical boundary issues that would otherwise complicate habilitation services (if the same staff were also delivering personal care services) will be mitigated.</p> <p>Personal care services are aimed at assisting the beneficiary with completing ADLs that would be performed independently if they had no disability. These services include:</p> <ul style="list-style-type: none">• Care to assist with daily living activities (e.g., eating, bathing, dressing, personal hygiene), cueing to prompt the beneficiary to perform a task and providing supervision to assist a beneficiary who cannot be safely left alone.• Health maintenance, such as bowel and bladder routines, ostomy care, catheter, wound care, and range of motion, as indicated in the beneficiary's Recovery Plan and permitted under applicable State requirements.• Routine support services, such as meal planning, keeping of medical appointments, and other health regimens needed to support the beneficiary.• Care and implementation of prescribed therapies.• Overnight personal care services to provide intermittent or ongoing awake, overnight care to a beneficiary in their home for up to eight hours. Overnight personal care services require awake staff. <p>Personal care may include care with the following activities when incidental to personal care and necessary to complete ADLs:</p> <ul style="list-style-type: none">• Activities that are incidental to the delivery of the personal care to assure the health, welfare, and safety of the beneficiary such as changing linens, doing the dishes associated with the preparation of a meal, laundering of towels from bathing may be provided and must not comprise the majority of the service. <p>Services to accompany the beneficiary into the community for purposes related to personal care, such as shopping in a grocery store, picking up medications, and providing care with any of the activities noted above to enable the completion of those tasks.</p>
Psychosocial rehabilitation (PSR)	<p>PSR services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid eligible adults with significant functional impairments meeting the need levels in the PROMISE program resulting from an identified mental health or substance abuse disorder diagnosis. The medical necessity for these rehabilitative services must be determined by a LBHP or physician who is acting within the scope of his/her professional license and applicable state law and furnished by or under the direction of a licensed practitioner, to promote the maximum reduction of symptoms and/or restoration of a beneficiary to his/her best age-appropriate functional level conducting an assessment consistent with state law, regulation, and policy. A unit of service is defined according to the HCPCS approved code set unless otherwise specified.</p> <p>Definitions</p> <p>PSR services are designed to assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness and/or SUD. Activities included must be intended to achieve the identified goals or objectives as set forth in the beneficiary's Recovery Plan. The intent of PSR is to restore the fullest possible integration of the beneficiary as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention. PSR is a face-to-face intervention with the beneficiary present. Services may be provided individually or in a group setting and should utilize (with documentation) evidence-based rehabilitation interventions. Group PSR sessions may not include more than eight beneficiaries in attendance. This service may include the following components:</p> <ul style="list-style-type: none">• Restoration, rehabilitation, and support with the development of social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, develop coping strategies, and effective functioning in the beneficiary's social environment including home, work, and school.

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	<ul style="list-style-type: none"> • Restoration, rehabilitation, and support with the development of daily living skills to improve self management of the negative effects of psychiatric or emotional symptoms that interfere with a beneficiary’s daily living. Supporting the beneficiary with development and implementation of daily living skills and daily routines critical to remaining in home, school, work, and community. • Assisting the beneficiary with implementing learned skills so the beneficiary can remain in a natural community location. • Assisting the beneficiary with effectively responding to or avoiding identified precursors or triggers that result in functional impairments. • Ongoing in-vivo assessment of the beneficiary’s functional skill and impairment levels that is used to select PSR interventions and periodically assess their effectiveness. Workers who provide PSR services should periodically report to a supervising licensed practitioner on the beneficiaries’ progress toward the recovery and re-acquisition of skills.
Respite	<p>Respite care includes services provided to beneficiaries unable to care for themselves furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the beneficiary. Respite may be provided in an emergency to prevent hospitalization. Respite provides planned or emergency short-term relief to a beneficiary’s unpaid caregiver or principle caregiver who is unavailable to provide support. This service will be provided to meet the beneficiary’s needs as determined by an assessment performed in accordance with department requirements and as outlined in the beneficiary’s Recovery Plan. Beneficiaries are encouraged to receive Respite in the most integrated and cost-effective settings appropriate to meet their respite needs.</p> <p>Respite services may include the following activities:</p> <ul style="list-style-type: none"> • Assistance with the beneficiary’s social interaction, use of natural supports and typical community services available to all people and participation in volunteer activities. • Activities to improve the beneficiary’s capacity to perform or assist with activities of daily living and instrumental activities of daily living. • Onsite modeling of behavior, behavior support, intensive behavior episode intervention, training, cueing, and/or supervision. <p>Respite 15-minute Unit Respite (15-minute unit) may be provided in the beneficiary’s home or out of the beneficiary’s home (not in a facility) in units of 15-minutes, for up to 12 hours a day. It is intended to provide short-term respite.</p> <p>Respite Per diem Respite (per diem) may be provided in a facility on a per diem basis. It is intended to provide short-term respite.</p> <p>Services must be delivered in a manner that supports the beneficiary’s communication needs including, but not limited to, age appropriate communication, translation services for beneficiaries that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider’s understanding, and use of communication devices used by the beneficiary.</p> <p>If the beneficiary is to receive respite on an ongoing basis, the care manager will monitor on a quarterly basis, as applicable, to see if the objectives and outcomes are being met.</p>
Short-term small group supported employment	<p>Short-term small group supported employment services provide support to beneficiaries to gain skills to enable transition to integrated, competitive employment. This service is provided, instead of IESS only when the beneficiary specifically chooses this service over IESS, based on a desire to work in a group context, or to earn income more quickly than might be possible with an individualized rapid job search through IESS. Short-term small group supported employment supports are services and training activities provided in regular business, industry, and community settings for groups of two (2) to four (4) workers with disabilities. Examples include mobile crews and other employment work groups. Small group employment support must be provided in a manner that promotes integration into the workplace and interaction between beneficiaries and people without disabilities in those</p>

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	<p>workplaces. The outcome of this service is sustained paid employment and work experience leading to further career development and beneficiary integrated community-based employment. Within this service, the beneficiary is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.</p> <p>Short-term small group supported employment supports may be a combination of the following services: on the job supports, initial and ongoing employment planning and advancement, employment assessment not otherwise covered in the annual career planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefits supports training and planning transportation. If the beneficiary has received a career assessment that has determined that the beneficiary is in need of acquiring particular skills in order to enhance their employability, those identified skill development areas must be addressed within the beneficiary's Recovery Plan and by the short-term small group supported employment support. Beneficiaries receiving this service must have an employment outcome goal included in their Recovery Plan.</p> <p>On the job support includes: onsite job training, assisting the beneficiary to develop natural supports in the workplace, coordinating with employers and coworkers, as necessary, to assist the beneficiary in meeting employment expectations and addressing issues as they arise. Other workplace support services may include services not specifically related to job skill training that enable the waiver beneficiary to be successful in integrating in to the job setting.</p> <p>Short-term small group supported employment supports includes person-centered, comprehensive employment planning and support service that provides assistance for waiver program beneficiaries to obtain, maintain, or advance in competitive employment or self-employment. This employment planning includes engaging a beneficiary in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state's minimum wage. The outcome of this activity is documentation of the beneficiary's stated career objective and a career plan used to guide beneficiary employment support.</p>

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Short-term small group supported employment supports emphasize the importance of rapid job search for a competitive job and provide work experiences where the beneficiary can develop strengths and skills that contribute to employability in individualized paid employment in integrated community settings. Short-term small group supported employment supports include the provision of scheduled activities outside of a beneficiary's home that support acquisition, retention, or improvement in self-care, sensory-motor development, socialization, daily living skills, communication, community living, and social skills. Short-term small group supported employment supports include supervision, monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills and training and education in self-determination. Skills development as a part of placement and training may occur as a one-to-one training experience in accordance with department requirements. Short-term small group supported employment supports will be utilized for a beneficiary to gain work related experience considered crucial for job placement (e.g., unpaid internship). Provide and support the acquisition of skills necessary to enable the beneficiary to obtain competitive, integrated work where the compensation for the beneficiary is at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities, which is considered to be the optimal outcome of short-term small group supported employment supports.

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

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

The short-term small group supported employment supports service provider must maintain documentation in accordance with department requirements. The documentation must be available to the care manager for monitoring at all times on an on-going basis. The care manager will monitor on a quarterly basis to see if the objectives and outcomes are being met.

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

Short-term small group supported employment supports emphasize the importance of rapid job search for a competitive job and provide work experiences where the beneficiary can develop strengths and skills that contribute to employability in individualized paid employment in integrated community settings. Short-term small group supported employment supports include the provision of scheduled activities outside of a beneficiary's home that support acquisition, retention, or improvement in self-care, sensory-motor development, socialization, daily living skills, communication, community living, and social skills. Short-term small group supported employment supports include supervision, monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills and training and education in self-determination. Skills development as a part of placement and training may occur as a one-to-one training experience in accordance with department requirements. Short-term small group supported employment supports will be utilized for a beneficiary to gain work related experience considered crucial for job placement (e.g., unpaid internship). Provide and support the acquisition of skills necessary to enable the beneficiary to obtain competitive, integrated work where the compensation for the beneficiary is at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities, which is considered to be the optimal outcome of short-term small group supported employment supports.

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	<p>the care manager for monitoring at all times on an on-going basis. The care manager will monitor on a quarterly basis to see if the objectives and outcomes are being met.</p> <p>Competitive and integrated employment, including self-employment, shall be considered the first option when serving persons with disabilities who are of working age.</p>
Community Transitions Services	<p>Community Transitions Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement where the person has a lease (e.g., apartment) or is in a private residence. The individual is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) necessary home accessibility adaptations; and, (g) activities to assess need, arrange for and procure need resources. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determining through the service plan development process clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes. Community Transition Services may not include payment for room and board. The payment of a security deposit is not considered rent. When Community Transition Services are furnished to individuals returning to the community from a Medicaid institutional setting through entrance to the waiver, the costs of such services are considered to be incurred and billable when the person leaves the institutional setting and enters PROMISE. The individual must be reasonably expected to be eligible for and to enroll in the waiver. If for any unseen reason, the individual does not enroll in the waiver (e.g., due to death or a significant change in condition), transitional services may be billed to Medicaid as an administrative cost. Community Transition Services may be furnished as a PROMISE service to individuals who transition from provider-operated settings other than Medicaid reimbursable institutions to their own private residence in the community. Community Transition Services may not be used to pay for furnishing living arrangements that are owned or leased by a PROMISE provider where the provision of these items and services are inherent to the service they are already providing. Community Transition Services are limited to \$1,800 per person but may be exceeded on a case-by-case basis with prior authorization based on medical necessity.</p>

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY**

NUMBER: 11-W-00036/4

TITLE: Delaware Diamond State Health Plan

AWARDEE: Delaware Department of Health & Social Services

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the demonstration project beginning December 19, 2014 through December 31, 2018, unless otherwise specified. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs). All previously approved waivers for this demonstration are superseded by those set forth below for the state's expenditures relating to dates of service during this demonstration extension.

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of the state plan requirements contained in section 1902 of the Act are granted in order to enable Delaware to implement the Delaware Diamond State Health Plan (DSHP) Medicaid section 1115 demonstration.

1. Amount, Duration, and Scope of Services **Section 1902(a)(10)(B) and 1902(a)(17)**

To the extent necessary to enable Delaware to offer a different benefit package to DSHP and DSHP-Plus participants than is being offered to the traditional Medicaid population. To the extent necessary to enable Delaware to provide additional services to enrollees in the Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) program.

2. Provision of Medical Assistance **Section 1902(a)(8) and 1902(a)(10)**

To the extent necessary to enable Delaware to limit the provision of medical assistance (and treatment as eligible) for individuals described in the eligibility group under section 1902(a)(10)(A)(ii)(XX) of the Act and the Medicaid State Plan to only former foster care youth who are under 26 years of age, were in foster care under the responsibility of another state or tribe on the date of attaining 18 years of age (or such higher age as the state has elected), were enrolled in Medicaid on that date, and are now residents in Delaware applying for Medicaid.

3. Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary to enable Delaware to restrict freedom-of-choice of provider through the use of mandatory enrollment into managed care plans for DSHP and DSHP-

Plus participants. To the extent necessary to enable the state to use selective contracted fee-for-service (FFS) providers, including for Home and Community Based Services (HCBS) and a transportation broker for non- medical transportation. No waiver of freedom of choice is authorized for family planning providers.

4. **Retroactive Eligibility**

Section 1902(a)(34)

To the extent necessary to enable Delaware to not extend eligibility to DSHP and DSHP-Plus participants prior to the date that an application for assistance is made, with the exception of institutionalized individuals in nursing facilities and workers with disabilities who buy-in for Medicaid coverage as outlined in Table A of the STCs.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 11-W-00036/4

TITLE: Delaware Diamond State Health Plan

AWARDEE: Delaware Department of Health & Social Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Delaware for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration extension, beginning December 19, 2014 through December 31, 2018 be regarded as expenditures under the state's title XIX plan. All previously approved expenditure authorities for this demonstration are superseded by those set forth below for the state's expenditures relating to dates of service during this demonstration extension.

The following expenditure authorities to provide coverage to the below list of demonstration populations may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable Delaware to implement the Delaware Diamond State Health Plan (DSHP) Medicaid section 1115 demonstration as outlined in the approved STCs:

- 1. 217-Like Elderly and Disabled Home and Community Based Services (HCBS) Group.** Expenditures for medical assistance for disabled individuals over age 18 who meet the Nursing Facility (NF) level of care (LOC) criteria and who would otherwise be Medicaid-eligible if the state had elected the group described in section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR 435.217 in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if enrolled and receiving services under a 1915(c) HCBS waiver program.
- 2. 217-Like HIV/AIDS HCBS Group.** Expenditures for medical assistance for individuals over age 1, who have a diagnosis of AIDS or HIV, who meet the hospital LOC criteria, and who would otherwise be Medicaid-eligible if the state had elected the eligibility group described in section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR 435.217 in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, and they were enrolled and receiving services under a 1915(c) HCBS waiver program.
- 3. "At-risk" for Nursing Facility Group.** Expenditures for medical assistance for disabled individuals over age 18 with incomes at or below 250 percent of the Supplemental Security Income (SSI) Federal Benefit Rate who do not meet the NF LOC, but are "at-risk" for institutionalization.
- 4. TEFRA-Like Group.** Expenditures for medical assistance for disabled children under age 18 with incomes at or below 250 percent of the SSI who do not meet the NF LOC, but are "at-risk" of institutionalization absent the provision of DSHP

services. The state will use financial institutional eligibility rules for individuals who would not be eligible in the community because of community deeming rules (in the same manner that would be used if the group were eligible under the state plan.

- 5. Continuing Receipt of Nursing Facility Care.** Expenditures for medical assistance for nursing facility residents, who do not currently meet the NF LOC criteria, but continue to meet the NF level of care criteria in place at the time of admission/enrollment.
- 6. Continuing Receipt of Home and Community-Based Services.** Expenditures for medical assistance for individuals receiving HCBS for the disabled and elderly, who do not meet the NF LOC criteria, but continue to meet the LOC criteria in place at the time of enrollment, including HCBS furnished under a terminated 1915(c) waiver.
- 7. Continuing Receipt of Medicaid State Plan Services.** Expenditures for medical assistance for disabled children with incomes at or below 250 percent of the SSI, who do not meet the NF or hospital LOC criteria, but continue to meet the LOC criteria in place at the time of their enrollment.
- 8. PROMISE Services.** Beginning January 1, 2015, expenditures for behavioral health services beyond the services described in the approved state plan for otherwise eligible individuals enrolled in the Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) program.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable or that are explicitly waived under the Waiver List, shall apply to demonstration populations beginning as of the date of the approval letter.