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

Administration and Operation

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

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

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

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

***Select one*:**

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

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

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

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

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

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

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

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

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

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

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

Provider relations functions include:

- enrolling service providers
- executing provider agreements

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

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

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

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

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

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

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

Number Served

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

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

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

Financial Eligibility

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

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

X The State does not provide State plan HCBS to the medically needy.

☐ The State provides State plan HCBS to the medically needy. (*Select one*):

☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.

☐ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

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

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

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

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

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

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

For all target groups, reevaluations are conducted by individuals holding an associate's degree or higher in a behavioral, social sciences, or a related field OR experience in health or human services support which includes interviewing individuals and assessing personal, health, employment, social or financial needs in accordance with program requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

Group A Individuals who are Visually Impaired Individuals are unemployed or underemployed or are at risk of losing their job without supports. Group B Individuals with Physical Disabilities Individuals whose physical condition affects their ability to live independently, who need ongoing assistance with at least 1 ADL and who are at risk of being unable to sustain competitive employment without supports. Group C Individuals with Intellectual Disabilities, Autism Spectrum Disorders or Asperger's Syndrome. Individuals with significant limitations in adaptive function and/or who need assistance with at least one area of ADL, and/or who have difficulty understanding and interpreting social situations and who are unlikely to be able to obtain or sustain competitive employment without supports.	The individual must have deficits in at least 2 ADLs.	Individual: 1) Has a diagnosis of intellectual or developmental disability and has been deemed eligible for services through the Division of Developmental Disabilities Services (DDDS). 2) Has been recommended for an ICF/IID level of care based on an assessment completed by a Qualified Intellectual Disability Professional, and includes the relevant medical and functional information necessary to evaluate an individual's need for an ICF/IID level of care. The diagnosis of Intellectual or Developmental Disability is determined based on: 1) The administration of the Adaptive Behavior Assessment System (ABAS) or Vineland Adaptive Behavior Scale (VABS) by a licensed psychologist, certified school psychologist or a licensed physician who practices psychiatry who certifies that the individual/applicant has significantly sub-average intellectual functioning or	

		otherwise meets the following criteria: b. An adaptive behavior composite standard score of 2 or more standard deviations below the mean; or a standard score of two or more standard deviations below the mean in one or more component functioning areas (ABAS: Conceptual, Social; Practical: VABS: Communication; Daily living Skills, Social).	

*Long Term Care/Chronic Care Hospital

**LOC= level of care

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

Delaware defines the following target groups:

Group A	Group B	Group C
Individuals who are Visually Impaired	Individuals with Physical Disabilities	Individuals with Intellectual Disabilities, Autism Spectrum Disorders or Asperger's Syndrome
Individuals age 14 to 25 determined by a doctor of optometry or ophthalmology to be: totally blind (no light perception), legally blind (20/200 in the better eye with correction, or a field restriction of 20 degrees or less) or severely visually impaired (20/70 to 20/200 in the better eye with correction).	Individuals age 14 to 25 with a physical disability; whose physical condition is anticipated to last 12 months or more.	Individuals age 14 to 25 with intellectual developmental disorder attributed to one or more of the following: IQ scores of 2 standard deviations below the mean, autism spectrum disorder, Asperger's disorder, Prader-Willi Syndrome, as defined in the APA Diagnostic and Statistical Manual, brain injury or neurological condition related to IDD that originates before age 22.

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

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

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

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

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

Home and Community-Based Settings

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

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

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

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

Pathways participants live in their own home or the home of a family member (owned or leased by the participant/participant's family for personal use). Participants residing in other settings will not be enrolled in the Pathways program. As part of the evaluation process for entry into the program, Employment Navigators will determine where applicants reside and will not enroll any applicant that does not live in a home as described above.

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

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

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

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

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

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

Person-Centered Planning & Service Delivery

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

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

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

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

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

Face-to-Face Assessments are conducted by Employment Navigators employed by the State (see Provider Qualifications for the Employment Navigator service under "Services". These individuals must have a minimum of an associate's degree or higher in a behavioral, social sciences or a related field OR experience in health or human services support, which includes interviewing individuals and assessing personal, health, employment, social or financial needs in accordance with program requirements.

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

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

POC development will be conducted by Employment Navigators employed by the State (see Provider Qualifications for the Employment Navigator service under "Services". These individuals must have a minimum of an associate's degree or higher in a behavioral, social sciences or a related field OR having experience in health or human services support, which includes interviewing individuals and assessing personal, health, employment, social or financial needs in accordance with program requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Services

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

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

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

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

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

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

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

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

In the performance of the coordinating function;

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

In the performance of the monitoring function;

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

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

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

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

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

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

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

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

(Choose each that applies):

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

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

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

Provider **The providers of this service will be limited per concurrent operation with the Pathways 1915(b)(4) waiver granting waiver of free choice of providers for this service, necessary to ensure conflict free status, access, and quality.**			procedures relating to provider qualifications. Individuals providing this service must be employed by the State of Delaware and must: • Have an associate's degree or higher in a behavioral, social sciences, or a related field OR experience in health or human services support, which includes interviewing individuals and assessing personal, health, employment, social, or financial needs in accordance with program requirements. • Complete Department-required training, including training on the participant's service plan and the participant's unique and/or disability-specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs. • Comport with other requirements as determined by the Department.

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

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

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

☐	Participant-directed	X	Provider managed

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

Service Title: Career Exploration and Assessment

Service Definition (Scope)*:*

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

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

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

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

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

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

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

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

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Career Exploration Agency	State Business License or 501 (c)(3) status	Pathways Certified Provider (utilizing DDDS HCBS Waiver Criteria)	Comply with all Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. Meet minimum standards as set forth by the Division of Vocational Rehabilitation or Division for the Visually Impaired as applicable for comparable services. Ensure employees complete Department-required training, including training on the participant's service plan and the participant's unique and/or disability-specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs. Individuals employed by providers must:

			• Have criminal background investigations in accordance with state requirements. • Have a screening against the child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del Code Section 708 and 11 Del Code Sections 8563 and 8564 and not have an adverse registry findings in the performance of the service. • Be state licensed (as applicable), or registered in their profession as required by state law. In the case of direct care personnel, possess certification through successful completion of training program as required by the Department.

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

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

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

☐	Participant-directed	X	Provider managed

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

Service Title:	Supported Employment-Individual

Service Definition (Scope)*:*

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

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

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

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Supported Employment Agency	State Business License or 501 (c)(3) status	Pathways Certified Provider (utilizing DDDS Waiver Criteria); and, DVR Vendor for Job Development, Placement and Retention Services	Comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. Meet minimum standards as set forth by the Division of Vocational Rehabilitation or Division for the Visually Impaired as applicable for comparable services. Ensure employees complete Department-required training, including training on the participant's service plan and the participant's unique and/or disability-specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs.

			Individuals employed by providers must: • Have criminal background investigations in accordance with state requirements. • Have a screening against the child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del Code Section 708 and 11 Del Code Sections 8563 and 8564 and not have an adverse 8564 and not have an adverse registry findings in the performance of the service. • Be state licensed (as applicable), or registered in their profession as required by state law. In the case of direct care personnel, possess certification through successful completion of training program as required by the Department

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

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

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

☐	Participant-directed	X	Provider managed

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

Service Title:	Supported Employment-Small Group

Service Definition (Scope)*:*

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

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

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

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

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

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

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

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

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

(Choose each that applies):

X	Categorically needy *(specify limits):*

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

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

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

		Development, Placement and Retention Services	applicable for comparable services. Ensure employees complete Department-required training, including training on the participant's service plan and the participant's unique and/or disability-specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs. Individuals employed by providers must: • Have criminal background investigations in accordance with state requirements. • Have a screening against the child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del Code Section 708 and 11 Del Code Sections 8563 and 8564 and not have an adverse registry findings in the performance of the service. • Be state licensed (as applicable), or registered in their profession as required by state law. In the case of direct care personnel, possess certification through successful completion of training program as required by the Department.

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

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

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

☐	Participant-directed	X	Provider managed

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

Service Title:	Benefits Counseling

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

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

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Benefits Counseling Agency	State Business License or 501 (c)(3) status		Comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. Ensure employees and/or contractors complete Department-required training, including training on the participant's service plan and the participant's unique and/or disability-specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs. Individuals employed or contracted by providers must: • Have a screening against the child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del Code Section 708 and 11 Del Code Sections 8563 and 8564 and not have an adverse registry findings in the performance of the service. • Be state licensed (as applicable), or registered in their profession as required by state law. In the case of direct care personnel, possess certification through successful completion of training program as required by the Department.

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

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

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

☐	Participant-directed	X	Provider managed

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

Service Title: Financial Coaching Plus

Service Definition (Scope)*:*

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

The Financial Coaching will:

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

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

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

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

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

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
X	Categorically needy *(specify limits):* Financial Coaching Plus service limited to five hours per participant per year.
☐	Medically needy *(specify limits):*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Financial Coaching Agency	State Business License or 501 (c)(3) status	An agency must demonstrate that Financial Coaches who will provide this service are certified in the financial coaching curriculum developed by the Department of Health and Social Services and the University of Delaware Alfred Lerner College of Business and Economics and the Division of Professional Continuing Studies.	Comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. The provider, including its parent company and its subsidiaries, and any sub provider, including its parent company and subsidiaries, agree to comply with the provisions of 29 Del Code Chapter 58, Laws Regulating the Conduct of Officers and Employees of the State and in particular with Section 5805 (d) Post Employment Restrictions. Ensure employees and/or contractors complete Department required training, including training on the participant's service plan and the participant's unique and/or disability specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs. Individuals employed or contracted by providers must:

			• Have criminal background investigations in accordance with state requirements. • Have a screening against the child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del Code Section 708 and 11 Del Code Sections 8563 and 8564 and not have an adverse registry findings in the performance of the service. • Be state licensed (as applicable), or registered in their profession as required by state law. • In the case of direct care personnel, possess certification through successful completion of training program as required by the Department. An agency must demonstrate that Financial Coaches who will provide this service: • Have at least one year of full time financial coaching experience. • Are trained in Financial Coaching Plus strategies specific to the Pathways population.

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

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

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

☐	Participant-directed	X	Provider managed

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

Service Title:	Non-Medical Transportation

Service Definition (Scope)*:*

Service offered in order to enable participants to gain access to employment services, as specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the Pathways program are offered in accordance with the participant's service plan. Whenever possible and as determined through the person-centered planning process, family, neighbors, friends, carpools, coworkers, or community agencies which can provide this service without charge must be utilized.

Non-medical Transportation services are offered, in addition to any medical transportation furnished under the 42 CFR 440.17(a) in the State Plan. Non-medical Transportation services are necessary, as specified by the service plan to enable individuals to gain access to employment services. In order to be approved, non-medical transportation would need to be directly related to a goal on the individual's treatment plan (e.g., to a supported employment) and not for the general transportation needs of the client (e.g., regular trips to the grocery store). This service will be provided to meet the individual's needs as determined by an assessment performed in accordance with Department requirements and as specifically outlined in the individual's POC.

Transportation services will be delivered through a transportation broker who will arrange and/or provide services pursuant to the plan of care. Such transportation may also include public transportation. The utilization of public transportation promotes self-determination and is made available to individuals as a cost-effective means of accessing services and activities. This service provides payment for the individual's use of public transportation to access employment.

The Employment Supports Coordinator will monitor this service quarterly and will provide ongoing assistance to the individual to identify alternative community-based sources of transportation.

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

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

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

(Choose each that applies):

X	Categorically needy *(specify limits):*
	The service does not provide for mileage reimbursement for a person to drive himself to work. Individuals may not receive this service at the same time as Supported Employment (individual or group) if those services are providing transportation to and from the employment setting.
☐	Medically needy *(specify limits):*

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

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Transportation Agency	Department or Designee	Initially and annually (or more frequent based on service monitoring concerns)

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

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

Service Title:	Personal Care

Service Definition (Scope)*:*

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

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

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

Personal Care may include escorting individuals to the workplace.

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

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

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

(Choose each that applies):

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

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home Health Agency	State Business License or 501 (c)(3) status; and State Home Health Agency License from Office of Health Facilities Licensing and Certification per Delaware Code Title 16-4406 Home Health Agencies (Licensure).	N/A	Comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. Complete and ensure employees complete Department-required training, including training on the participant's service plan and the participant's unique and/or disability-specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs. Individuals employed by providers must: • Be at least 18 years of age.

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

Personal Attendant	N/A	N/A	• Must have the ability to carry out the tasks required by the participant. • Must have the ability to communicate effectively with the participant. • Have criminal background investigations in accordance with state requirements. • Have a screening against the child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del Code Section 708 and 11 Del Code Sections 8563 and 8564 and not have an adverse registry findings in the performance of the service. • Must be at least 18 years of age. (Exceptions to the age requirement are made on a case-by-case basis and require written authorization by the participant case manager.) • Must complete training through Support for Participant Direction vendor within 90 days of enrollment as a provider. (Exceptions to the training requirement are made by the Support for Participant Direction vendor on a case-by-case basis for emergency back-up providers.)

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

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

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

☐	Participant-directed	X	Provider managed

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

Service Title: Orientation, Mobility, and Assistive Technology

Service Definition (Scope)*:*

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

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

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

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

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

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

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

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

Orientation and Mobility

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

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

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

Services must be delivered in a setting that complies with HCB standards.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
X	Categorically needy *(specify limits):*
	These assessments, items or services must not otherwise be available to individuals under the DSHP or DSHP Plus Program. Assistive Technology devices must be obtained at the lowest cost. The amount of this service for Assistive Technology devices is limited to $10,000 for the participant's lifetime. This amount includes replacement parts and repair when it is more cost effective than purchasing a new device. Exceptions to this limit may be considered based upon a needs assessment and prior authorization by the Department.
☐	Medically needy *(specify limits):*

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

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

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

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

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

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

☐	Participant-directed	X	Provider managed

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

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

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

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

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

Participant-Direction of Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Voluntary Termination of Participant Direction

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

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

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

Involuntary Termination of Participant Direction

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

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

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

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

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

8. Opportunities for Participant-Direction

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

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

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

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

Quality Improvement Strategy

Quality Measures

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

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

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

3. **Providers meet required qualifications.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Requirement	The State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.
Discovery	
Discovery Evidence *(Performance Measure)*	1. The percentage of incidents of Abuse/Neglect/Mistreatment that were reported in accordance with Pathways requirements. 2. The percentage of incidents of Abuse/Neglect/Mistreatment by type in which follow-up was completed in accordance with applicable Department requirements. 3. The percentage of employed participants reporting that they feel safe at work. (The number of participants reporting that feel safe at work/number of participants whose services and supports were reviewed) 4. The percentage of reported incidents of emergency restrictive behavior intervention

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

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

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

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

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

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

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

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

2. Roles and Responsibilities

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

3. Frequency

Continuously and ongoing

4. Method for Evaluating Effectiveness of System Changes

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

Methods and Standards for Establishing Payment Rates

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

X	HCBS Case Management
	Reimbursement is based on a fee schedule that sets a fee for the Employment Navigator provider. The fee development methodology is composed of provider cost modeling using information from independent data sources (as available), through Delaware provider compensation studies, cost data, and fees from similar State Medicaid programs may be considered, as well. Providers of Employment Navigator services are reimbursed on the basis of a payment for a week's provision of service for each participant enrolled for any portion of the month based on reasonable and proper costs for service provision based on federally accepted reimbursement principles (Medicare or OMB A-87 principles) and review of actual costs of operation for the year preceding implementation from a review of financial and statistical reports. Employment Navigation services will not be subject to cost settlement. The weekly unit includes all Employment Navigator services provided to the participant during the week. The provider qualifications related to employment navigator services is defined in Attachment 3.1-I, on page 15. *The following list outlines the major allowable cost components to be used in fee development.* • *Staffing Assumptions and Staff Wages* • *Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation)* • *Staff Productivity Assumptions (e.g., time spent on billable activities)* • *Program-Related Expenses (e.g., technology related expenses, supplies)* • *Provider Overhead Expenses* *The fee schedule rates will be developed as the total annual provider costs, converted to a weekly unit of service per participant. Providers must maintain detailed accounting of actual costs incurred for Employment Navigator salaries, other employment costs and program-related costs such as technology, rent, cost of supervision, etc. for each program year. This data will be provided to DMMA within three months of the close of the program year. The State will compare this data to the wage scale data used to establish the rates to ensure that the wage scale data is representative of industry-standard costs.* *Billing on a weekly basis is more economical than using 15-minute increments because the amount of bookkeeping is drastically reduced. Employment Navigators must still document all billable activity. For each program year, a projected weekly rate is established, based on reasonable and proper costs of operation pursuant to federally accepted reimbursement principles.* *The agency's fee schedule rate was set as of 1/1/15 and is effective for services provided on or and the fee schedule and any annual/periodic adjustments to the fee schedule are published in http://www.dhss.delaware.gov/dsaapd/pathways.html.*
☐	HCBS Homemaker

☐	HCBS Home Health Aide
X	HCBS Personal Care
	Personal care reimbursement rates will be established as a percentage of the DMMA FFS Home Health Aide agency rate. The state will establish Home Health agency, Personal Care Agency, and self-directed services rates as follows: Home Health Agency Rate as a Percent of DMMA HHA Rate: 84% Personal Care Agencies as a Percent of DMMA HHA Rate: 73% Participant-directed as a Percent of DMMA HHA Rate: 43%, reflecting the removal of reimbursement for administrative functions that will be supported through other means. Reimbursement for Home Health services will be paid at 84% of the DMMA HHR rate per Attachment 4.19-B, page 6. Reimbursement for Personal Care Services will be paid at 73% of the DMMA HHR rate per Attachment 4.19-B, page 15. Reimbursement for Personal Care Services associated with the self-directed option will be paid at 43% of the DMMA HHR rate per Attachment 4.19-B, page 15.
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☐	HCBS Respite Care

For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
X		Other Services (specify below)
		Career Exploration and Assessment Rates for Career Exploration and Assessment are based upon the rate established for Pre-Vocational Service, which was calculated using a market basket methodology. This rate methodology is comprised of four key components: • direct support professional wage ($)

	• employee related expenses (%) • program indirect expenses (%) • administrative expenses (%) Wage data was obtained from authoritative sources such as the U.S. DOL Bureau of Labor Statistics for job classifications with similar requirements and duties as the direct support professionals performing Pre-vocational service in order to derive an appropriate DSP hourly wage rate. In developing the other three rate components, provider cost data for the allowable costs included in the "market basket" was collected through cost reports and follow up interviews. These costs are converted to percentages that are multiplied by the direct support hourly wage rate as a set of recursive percentages in order to develop an hourly provider DSP rate for each service. The agency's fee schedule rate was set as of 1/1/15 and is effective for services provided on or after that date. All rates are published on the agency's website at *http://www.dhss.delaware.gov/dsaapd/pathways.html*. Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published in *http://www.dhss.delaware.gov/dsaapd/pathways.html*.
	Supported Employment – Individual Rates for Individual Supported Employment have been calculated using provider cost modeling using information from independent data sources (as available), through Delaware provider compensation studies, cost data and fees from similar State Medicaid programs may be considered as well. Total Medicaid allowable costs were tabulated and divided by total direct care staff (job coaches, employment specialists) billable hours. This provided a cost per hour based on direct care staff hours. The hourly rate will be expressed as a 15 minute billable unit by dividing the hourly rate by four. The agency's fee schedule rate was set as of 7/1/14 and is effective for services provided on or after that date. All rates are published on the agency's website at *http://www.dhss.delaware.gov/dsaapd/pathways.html*. Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published in *http://www.dhss.delaware.gov/dsaapd/pathways.html*.
	Supported Employment - Small Group Rates for Small Group Supported Employment are based on the rate for Individual Supported Employment, which is a one-to-one staff-to-consumer ratio. The payment rate for the addition of each consumer in the group shall be computed by dividing the payment rate for Individual Supported Employment by the number of participants in the group (up to a maximum of 4) and applying a gross up factor to account for additional incremental costs related to the provision of group supported employment that would not have been captured in the base rate for Individual Supported Employment. Small Group Supported Employment will be paid in 15 minute billable units. The agency's fee schedule rate was set as of 7/1/14 and is effective for services provided on or after that date. All rates are published on the agency's website at

	http://www.dhss.delaware.gov/dsaapd/pathways.html. Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published in *http://www.dhss.delaware.gov/dsaapd/pathways.html*.
	Non-Medical Transportation Non-Medical transportation will be implemented utilizing a transportation broker. The state will pay the broker on a fee-for-service basis with administrative compensation for the coordination and delivery of transportation. The rates will be one of the following, depending on the most direct, cost effective mode of transport: - Per mile (using established state reimbursement per mile) - Per public transportation trip using fees established by public transportation agency(ies) Per trip, using a methodology based upon average miles per trip, number of individuals in transport and any specialized mode of transportation required.
	Benefits Counseling The fee development methodology is composed of provider cost modeling using information from independent data sources (as available), though Delaware provider compensation studies, cost data, and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major allowable cost components to be used in fee development. • Staffing Assumptions and Staff Wages • Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation) • Staff Productivity Assumptions (e.g., time spent on billable activities) • Program Indirect Expenses (e.g., supplies) • Provider Overhead Expenses The fee schedule rates will be developed as the total hourly provider costs, adjusted for productivity and converted to the applicable unit of service. The agency's fee schedule rate was set as of 1/1/15 and is effective for services provided on or after that date. All rates are published on the agency's website at *http://www.dhss.delaware.gov/dsaapd/pathways.html.* Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published in *http://www.dhss.delaware.gov/dsaapd/pathways.html*.
	Financial Coaching Plus The fee development methodology is composed of provider cost modeling using information from independent data sources (as available), though Delaware provider compensation studies, cost data, and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major allowable cost components to be used in fee development.

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

The fee schedule rates will be developed as the total hourly provider costs, adjusted for productivity and converted to the applicable unit of service.

The agency's fee schedule rate was set as of 1/1/15 and is effective for services provided on or after that date. All rates are published on the agency's website at *http://www.dhss.delaware.gov/dsaapd/pathways.html.* Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published in *http://www.dhss.delaware.gov/dsaapd/pathways.html*.

Orientation, Mobility, and Assistive Technology

The fee development methodology is composed of provider cost modeling using information from independent data sources (as available), though Delaware provider compensation studies, cost data, and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major allowable components to be used in fee development.

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

The fee schedule rates will be developed as the total hourly provider costs, adjusted for productivity, and converted to the applicable unit of service.

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

The agency's fee schedule rate was set as of 1/1/15 and is effective for services provided on or after that date. All rates are published on the agency's website at *http://www.dhss.delaware.gov/dsaapd/pathways.html.* Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published in *http://www.dhss.delaware.gov/dsaapd/pathways.html*.

Groups Covered

Optional Groups other than the Medically Needy

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

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

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

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

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

☐ OTHER (*describe*):

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

☐ 300% of the SSI/FBR

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

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

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

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