DELAWARE HEALTH
AND SOCIAL SERVICES
DIVISION OF
MEDICAID & MEDICAL ASSISTANCE

OFFICE OF THE DIRECTOR

August 29, 2014

Ms. Cynthia Mann
Director
Center for Medicaid and State Operations
7500 Security Blvd., Mail Stop S2-26-12
Baltimore, MD 21244-1850

Dear Ms. Mann,

On March 22, 2012, CMS approved Delaware's request to amend its section 1115 Medicaid Demonstration project entitled, "Diamond State Health Plan (DSHP)." CMS' approval of the amendment to this demonstration, effective April 1, 2012 through December 31, 2013, gave the State of Delaware authority to include Long-Term Care clients in Managed Care.

Today, the State of Delaware is submitting a request to amend the 1115 Demonstration Waiver Project, number 11-W-00036, to change the behavioral health delivery system titled, "PROMISE." We are submitting documentation that describes the program changes while concurrently fulfilling the transparency process. All documentation is herein attached.

Glyne Williams is the Chief Administrator of Medical Management Services for the State of Delaware. Mr. Williams can be reached by email at Glyne.Williams@state.de.us or by calling (302) 255-9628.

Thank you for your consideration of the proposed amendment. We look forward to continuing to work with CMS in administering this demonstration.

Sincerely,

[redacted]

Stephen M. Groff,
DMMA Director

Cc: Francis McCullough, CMS Associate Regional Administrator
Shanna Wiley (CMS/CMCS), Project Officer, Division of State Demonstrations & Waivers
Glyne Williams, Chief Administrator, Medical Management

# 1115 Demonstration Amendment for State of Delaware PROMISE (Promoting Optimal Mental Health for Individuals through Supports and Empowerment) Program Changes

## August 22, 2014

## Introduction

The State of Delaware (State) is seeking an amendment to their existing 1115 demonstration waiver to comprehensively meet the needs of individuals with behavioral health (BH) needs, including individuals identified under the State's Olmstead settlement with the United States Department of Justice. The 1115 demonstration amendment is being submitted following submission of a State Plan Amendment (SPA) for crisis intervention, substance use disorder (SUD) treatment, and treatment by other licensed practitioners.

The PROMISE program seeks authority to target individuals with behavioral health needs and functional limitations in a manner similar to an Home and Community-Based Services (HCBS) 1915(i) State Plan authority. The HCBS authority under an 1115 amendment is sought, instead of a 1915(i) State Plan Amendment, to ensure coordination with the Diamond State Health Plan (DSHP) Plus program, to allow the State to include State Plan BH services in the managed care organization (MCO) benefit package, and to allow the State to competitively procure vendors under its new HCBS BH program, identified as PROMISE *(Promoting Optimal Mental Health for Individuals through Supports and Empowerment).* The demonstration amendment ensures that the freedom of choice waiver required for the procurement under this new HCBS program is granted under the State's current 1115 demonstration waiver and includes all affected individuals' costs under a single Centers for Medicare and Medicaid Services (CMS) authority. In particular, because of the small size of the State and low volume of services needed, the State will be competitively procuring contractors under the demonstration to meet the high quality and fidelity standards required under the Olmstead ADA settlement.

- For adult Medicaid populations meeting targeting and functional limitations statewide, the State will offer an enhanced benefit package of HCBS using HCBS authority in the 1115 demonstration. Generally, this includes individuals meeting the Olmstead settlement BH target population as well as other Medicaid-eligible adults with serious mental illness and/or substance use disorder needs requiring HCBS to live and work in the most integrated setting. These services are provided in addition to the State Plan services to help maintain individuals in home and community-based settings. The enhanced Medicaid benefit package will be coordinated by the Division of Substance Abuse and Mental Health (DSAMH) through the fee-for-service (FFS) program in compliance with home and community-based standards and assurances and the signed Olmstead agreement. *This population will continue to receive non-BH and most non-enhanced BH Medicaid State Plan services through the MCO benefit.* See the benefit sections below for a description of the covered services. The State is also considering including non-medical transportation services in the State's existing transportation broker contract and this amendment would provide the freedom of choice authority necessary for that contract amendment.
- For adults served in MCOs throughout the State who are not in the PROMISE target populations, the MCOs will integrate all covered services for mental illness, SUDs, and physical health (PH) conditions under this demonstration.

The goals of the two delivery system models are to improve clinical and recovery outcomes for individuals with BH needs and reduce the growth in costs through a reduction in unnecessary

institutional care through care coordination, including initiatives to increase network capacity to deliver community-based recovery-oriented services and supports. This structure will also ensure care continuity for individuals depending on their levels of need.

## Background

Many individuals who are not currently eligible for Medicaid receive critical BH services through State-only funds, federal block grant dollars, or other resources. Although the State already has expanded Medicaid eligibility, many of the individuals served in the BH system who have not historically been eligible for Medicaid become eligible for Medicaid under health care reform in 2014. Under this proposed demonstration amendment, the State plans to develop access to additional supports and services to better meet the BH needs of the Medicaid expansion population in 2014 and to better serve the target populations under the Olmstead settlement. These efforts are aimed at modernizing and improving the delivery of mental health and substance use services in Delaware to better meet the needs of those currently eligible, but also to build the foundation to ensure that there is a robust continuum of supports and evidenced-based options available in the future. It is the State's intention to offer the expansion population the same benefit package as the rest of Medicaid with any necessary wraps to ensure essential health benefits.

The management of severe and persistent mental illness (SPMI) and chronic and disabling SUD require specialized expertise, tools, and protocols which are not consistently found within most medical plans. As a result, for adult populations meeting the SPMI and SUD targeting and functional criteria statewide, specialty BH care within the State will be care managed by DSAMH on a FFS basis with MCO care managers participating in person-centered planning with DSAMH and the participants to fully integrate PH needs with BH needs.

The demonstration amendment seeks to address the issues arising from special needs populations with SPMI and/or SUD through a comprehensive, interconnected approach to providing services to all individuals with BH needs in Delaware, ensuring that the individuals served are receiving the most appropriate services to meet their needs in the most integrated settings possible.

## PROMISE Program

In order to better treat individuals meeting SPMI and SUD targeting and functional needs criteria, Delaware will be providing an enhanced benefit package of HCBS services to adults (ages 18 and older) meeting the targeting and functional needs criteria for SPMI and SUD under the PROMISE program. All individuals who meet the targeting and functional needs criteria will receive specialized care management and care coordination consistent with established protocols for managing care for adults with SPMI and/or SUD. This includes providing for behavioral supports in community-based settings (individuals' own homes), as well as residential, employment, and day settings to help individuals live in the most integrated setting possible. DSAMH, through its network of care managers and providers, will ensure that all HCBS requirements and assurances are met. This initiative is intended to fundamentally meet the requirements of the Olmstead agreement signed with the United States Department of Justice, and to build a sustainable behavioral health system for Delaware.

### PROMISE Eligibility Requirements

Demonstration enrollees applying for services must be screened by DSAMH using a standardized clinical and functional assessment developed for Delaware and based on national standards.

Individuals in PROMISE will not be eligible for the State's new Pathways 1915(i) State Plan Amendment Program because the PROMISE program is a more comprehensive program that includes all Pathways services as well as other services necessary for individuals with behavioral health needs to be supported in their homes. The Delaware-specific American Society for Addiction Medicine (ASAM) tool integrates the assessment and evaluation of both mental health and SUD conditions into a single document with an algorithm that can be used to determine functional eligibility and is designed to ensure appropriate treatment of individuals based on their medical and functional needs. State Medicaid eligibility staff will review financial criteria to ensure that applicants meet the community financial eligibility criteria. Individuals eligible for and enrolled in PROMISE may also be enrolled in the PLUS program if meeting the criteria for both programs unless the PROMISE individual has been identified as a CRISP individual under the ADA settlement. If the individual is identified as a CRISP individual, the individual will be enrolled in the PROMISE program only and will receive all services necessary for community living from the PROMISE program through CRISP. The CRISP program will not provide any services under the acute care MCO benefit. The PROMISE program will ensure that Medicaid payments are backed out of any state-only capitated payments made for the CRISP program thus ensuring no duplicate payment between CRISP/PROMISE and Plus. For individuals in PROMISE and PLUS, medically necessary PROMISE services will be provided in addition to any services that the individual is otherwise eligible for in PLUS if the individual is assessed as needing additional services and the services are outlined on the individuals Recovery Plan. The PROMISE care manager will coordinate with the Plus case manager, who will lead the individual's care team. To be eligible under the PROMISE HCBS program, individuals must meet one of the targeting criteria and the corresponding functional criteria under the Delaware-specific tool. The following are acceptable combinations for individuals eligible under the demonstration:

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

### *Targeting Criteria*

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

| DSAMH Current SPMI Diagnosis Codes (updated 7/1/2012) | | | |
|---|---|---|---|
| **DSM IV Code** | **DSM 5 Code** | **Disorder** | **DSM IV Category** |
| 295.10 | 295.90 | Schizophrenia, Disorganized Type *(In DSM 5 Disorganized subtype no longer used)* | Psychotic Disorders[1] |
| 295.20 | 295.90 | Schizophrenia, Catatonic Type *(In DSM 5 Catatonic subtype no longer used)* | Psychotic Disorders |
| 295.30 | 295.90 | Schizophrenia, Paranoid Type *(In DSM 5 Paranoid subtype no longer used)* | Psychotic Disorders |
| 295.40 | 295.40 | Schizophreniform Disorder | Psychotic Disorders |
| 295.60 | 295.90 | Schizophrenia, Residual Type *(In DSM 5 Residual subtype no longer used)* | Psychotic Disorders |
| 295.70 | 295.70 | Schizoaffective Disorder | Psychotic Disorders |

[1] In DSM 5, the associated diagnostic category is labeled, "Schizophrenia Spectrum and Other Psychotic Disorders".

| DSAMH Current SPMI Diagnosis Codes (updated 7/1/2012) | | | |
|---|---|---|---|
| **DSM IV Code** | **DSM 5 Code** | **Disorder** | **DSM IV Category** |
| 295.90 | 295.90 | Schizophrenia, Undifferentiated Type *(In DSM 5 Undifferentiated subtype no longer used)* | Psychotic Disorders |
| 296.30 | 296.30 | Major Depressive Disorder, Recurrent, Unspecified | Mood Disorders[2] |
| 296.32 | 296.32 | Major Depressive Disorder, Recurrent, Moderate | Mood Disorders |
| 296.33 | 296.33 | Major Depressive Disorder, Recurrent, Severe Without Psychotic Features *(In DSM 5, "Without Psychotic Features" is not a further specifier)* | Mood Disorders |
| 296.34 | 296.34 | Major Depressive Disorder, Recurrent, Severe With Psychotic Features *(In DSM 5, "With psychotic features" is its own specifier, and, when present, is used instead of Mild, Moderate, or Severe, not in addition to Severe)* [3] | Mood Disorders |
| 296.40 | 296.40 | Bipolar I Disorder, Most Recent Episode Hypomanic[4] | Mood Disorders |
| 296.42 | 296.42 | Bipolar I Disorder, Most Recent Episode Manic, Moderate | Mood Disorders |
| 296.43 | 296.43 | Bipolar I Disorder, Most Recent Episode Manic, Severe Without Psychotic Features *(In DSM 5, "Without Psychotic Features" is not a further specifier)* | Mood Disorders |
| 296.44 | 296.44 | Bipolar I Disorder, Most Recent Episode Manic, Severe With Psychotic Features *(In DSM 5, "With psychotic features" is its own specifier, and, when present, is used instead of Mild, Moderate, or Severe, not in addition to Severe)*[5] | Mood Disorders |
| 296.50 | 296.50 | Bipolar I Disorder, Most Recent Episode Depressed, Unspecified | Mood Disorders |
| 296.52 | 296.52 | Bipolar I Disorder, Most Recent Episode Depressed, Moderate | Mood Disorders |
| 296.53 | 296.53 | Bipolar I Disorder, Most Recent Episode Depressed, Severe w/o Psychotic Features *(In DSM 5, "Without Psychotic Features" is not a further specified)* | Mood Disorders |
| 296.54 | 296.54 | Bipolar I Disorder, Most Recent Episode Depressed, Severe w/ Psychotic Features *(In DSM 5, "With psychotic features" is its own specifier, and, when present, is used instead of Mild, Moderate, or Severe, not in addition to Severe)*[6] | Mood Disorders |
| 296.60 | | Bipolar I Disorder, Most Recent Episode Mixed, Unspecified *(This Bipolar 1 sub-type was removed from DSM 5)* | Mood Disorders |
| 296.62 | | Bipolar I Disorder, Most Recent Episode Mixed, Moderate *(This Bipolar 1 sub-type was removed from DSM 5)* | Mood Disorders |
| 296.63 | | Bipolar I Disorder, Most Recent Episode Mixed, Severe Without Psychotic Features *(This Bipolar 1 sub-type was removed from DSM 5)* | Mood Disorders |

[2] In DSM 5, mood disorders are broken out into "Depressive Disorders" and "Bipolar and Related Disorders".

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

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

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

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

| DSAMH Current SPMI Diagnosis Codes (updated 7/1/2012) | | | |
|---|---|---|---|
| **DSM IV Code** | **DSM 5 Code** | **Disorder** | **DSM IV Category** |
| 296.64 | | Bipolar I Disorder, Most Recent Episode Mixed, Severe With Psychotic Features *(This Bipolar 1 sub-type was removed from DSM 5)* | Mood Disorders |
| 296.70 | 296.70 | Bipolar Disorder, Most Recent Episode Unspecified | Mood Disorders |
| 296.89 | 296.89 | Bipolar II Disorder | Mood Disorders |
| 297.1 | 297.1 | Delusional Disorder | Psychotic Disorders |
| 301.0 | 301.0 | Paranoid Personality Disorder | Personality Disorders |
| 301.20 | 301.20 | Schizoid Personality Disorder | Personality Disorders |
| 301.22 | 301.22 | Schizotypal Personality Disorder | Personality Disorders |
| 301.83 | 301.83 | Borderline Personality Disorder | Personality Disorders |
| 309.81 | 309.81 | Posttraumatic Stress Disorder (PTSD) | Anxiety Disorders[7] |

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

- Mood Disorders:
  - *In DSM 5 "Depressive Disorders" and "Bipolar and Related Disorders" are separated out as diagnostic groupings.*
- Anxiety Disorders:
  - *DSM 5 includes a separate category, "Obsessive-Compulsive and Related Disorders".*
  - *DSM 5 includes a separate category, "Trauma- and Stressor-Related Disorders".*
- Schizophrenia and Other Psychotic Disorders:
  - *In DSM 5 this category is labeled, "Schizophrenia Spectrum and Other Psychotic Disorders".*
- Dissociative Disorders
- Personality Disorders
- Substance-Related Disorders:
  - *In DSM 5 this category is labeled, "Substance-Related and Addictive Disorders".*

### *Functioning Criteria*

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

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

Functional Criteria A: If the individual meets Targeting Criteria A, the individual must be assessed with a rating of moderate on at least one of the six Delaware-specific ASAM dimensions. The six dimensions include the following[8]:

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

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

Functional Criteria C: An adult who has previously met the above targeting and functional criteria and needs subsequent medical necessary services for stabilization and maintenance. The individual continues to need at least one HCBS service for stabilization and maintenance (i.e., at least one PROMISE service described below in Table 3).

## PROMISE Benefits and Cost-Sharing

Effective with MCO re-procurement, adults under PROMISE will receive through MCOs all non-BH Medicaid State Plan services, as well as the following State Plan non-enhanced BH services:

- Hospital (inpatient general hospitals including BH stays in psychiatric units[9]; emergency room (ER); outpatient; inpatient psychiatric care the age 21[10]).
- Physician — all types except for psychiatric providers employed by and providing supervision to the PROMISE program services of assertive community treatment (ACT), intensive case management (ICM), and residential supports.
- Pharmacy — all excluding medication assisted treatment.
- Crisis intervention.

The following BH State Plan services will be provided FFS with care coordination through DSAMH for adults receiving services under PROMISE:

- SUD services including medication assisted treatment.
- Services by licensed BH practitioners.

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

[9] 42 CFR 440.10.

[10] 42 CFR 440.160. Note: because this program is for individuals ages 18 and over, this reference to adults in inpatient psychiatric care under age 21 refers to individuals ages 18-21 as indicated under the approved Delaware State Plan.

Until MCO re-procurement, the MCO benefit package for BH will remain unchanged for all Medicaid members. The changes to the MCO benefit package outlined above will be effective with MCO re-procurement.

All services, both FFS and those delivered through the MCO, will be closely coordinated to ensure optimal outcomes for individuals served.

Additionally, adults meeting the targeting and functional needs will receive the HCBS services under PROMISE noted in the table below on a FFS basis. Definitions of these services may be found in Appendix A. It is not anticipated that the State will utilize institutional financial eligibility standards under this portion of the demonstration (i.e., no .217-like group). Therefore, patient liability is not applicable, and consistent with Medicaid regulations and statutes, will not be collected for individuals eligible for Medicaid under the community financial standards.

These services will be delivered pursuant to a written plan of care called the Recovery Plan that is developed with a person-centered process in consultation with the individual, and others at the option of the individual, such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes. The process:

- Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports.
- Prevents the provision of unnecessary and/or inappropriate care.
- Identifies the HCBS that the individual is assessed to need.
- Includes any HCBS in which the individual has the option to self-direct the purchase or control.
- Is guided by best practices and research on effective strategies for improved health and quality of life outcomes.
- Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.

**PROMISE HCBS Services for Adults Meeting Targeting and Functional Needs**

| Services | Currently in the Medicaid State Plan | PROMISE Enhanced Benefit for Adults Meeting Targeting and Functional Criteria |
|---|---|---|
| Care management | No | Yes |
| Benefits counseling | No | Yes |
| Community psychiatric support and treatment | No | Yes |
| Community-based residential supports, excluding assisted living | No | Yes |
| Financial coaching | No | Yes |
| Independent activities of daily living/chore | No | Yes |
| Individual employment supports | No | Yes |
| Non-medical transportation | No | Yes |
| Nursing | No | Yes |
| Peer support | No | Yes |
| Personal care | No | Yes |
| Psychosocial rehabilitation | No | Yes |

| Services | Currently in the Medicaid State Plan | PROMISE Enhanced Benefit for Adults Meeting Targeting and Functional Criteria |
|---|---|---|
| Respite | No | Yes |
| Short-term small group supported employment | No | Yes |
| Community Transition Services | No | Yes |

## Delivery System and Payment Rates for Services

Utilizing the freedom of choice waiver granted under this demonstration and using a tailored procurement process in accordance with the timeframes set forth on page 9, DSAMH will contract with providers meeting the PROMISE HCBS requirements and in fidelity with evidence-based practices as required by the Olmstead agreement. All adults receiving PROMISE services will have a choice of practitioner among the contracted and qualified providers. Individuals eligible under the PROMISE authority will receive care management via care managers in the DSAMH system that report to the eligibility and enrollment unit in the single State agency. The designated State care manager will serve as the care manager under the PROMISE authority in close conjunction with the care manager designated by the MCO for benefits under the MCO benefit package. Delaware has undertaken strategies to ensure a system of conflict free case management, in accordance with applicable guidelines, including ensuring that care managers are not providers or employed by providers on the Recovery Plan. Individuals must reside in home and community-based settings to receive PROMISE services.

DSAMH is a part of the single State Medicaid agency, the Department of Health and Social Services, and will have delegated authority from the Division of Medicaid and Medical Assistance (DMMA) to operate the PROMISE benefits. DSAMH is the primary division responsible for ensuring that the State complies with the reporting and oversight requirements in the signed Olmstead agreement. DMMA quality oversight strategies will include data elements to oversee DSAMH's performance in the execution of those HCBS functions. The current Delaware Quality Management Strategy will be updated to include any oversight needed of the PROMISE program and will outline any delegated responsibilities to the DSAMH division as well as oversight by DMMA.

Delaware DMMA and DSAMH have been working in close partnership in the development of these benefits and will ensure that the following occur in the FFS program:

- Adequate provider capacity in specialty BH services.
- Timely member transitions to the PROMISE provider network ensuring continuity of care, and ongoing close coordination to ensure integrated physical and behavioral healthcare.
- Implementation of documented Medicaid management information systems functionality, processes, and claims administration.
- Adequate member service functionalities outlined in the Olmstead settlement, including the call line and recipient communications.
- Sufficient staffing resources, requirements (education, training, experience) and performance monitoring.
- Complete reporting capabilities including: utilization, cost, financial, quality and administrative indicators, and performance metrics required of HCBS programs.

In order to develop a comprehensive non-medical transportation benefit, administered by a single statewide broker, Delaware seeks to limit providers of this service through authority granted

through this demonstration to waiver 1902(a)(23). Such authority will allow non-medical transportation services be delivered through HCBS authorities.

### PROMISE Reporting, Program Monitoring, and Quality Management

In order to ensure strong management of the SPMI and SUD populations, data will be monitored and aggregated consistent with the State's definitions under the PROMISE program.

The State will develop HCBS performance measures and monitoring consistent with the State's managed long term supports and services program (i.e., DSHP Plus) and already existing standard terms and conditions for the population under the existing demonstration including the quality of life measurements outlined in the Olmstead settlement. The State will comply with all federal HCBS requirements upon initial implementation of the PROMISE program.

## Adults Not Meeting PROMISE Eligibility Criteria

All adult BH services for individuals over 18 not meeting PROMISE targeting and functional criteria will be delivered through the MCO benefit package effective with the MCO reprocurement. Adults not eligible for the PROMISE program will receive the following State Plan services through their MCOs:

- Hospital (inpatient general hospitals and psychiatric units; ER; outpatient; inpatient psychiatric for those under age 21).
- Physician — all types.
- Pharmacy — excluding medicated assisted therapy (MAT).
- Crisis intervention.
- SUD services, including MAT.
- Services by licensed BH practitioners.

Until MCO re-procurement, the MCO benefit package for BH will remain unchanged for all Medicaid members.

In short, beneficiaries who do not meet the PROMISE criteria are enrolled in managed care and all behavioral benefits for which they are eligible are provided under that delivery system. The goal of incorporating the BH services for the general adult population in the MCOs is to improve access to appropriate physical and BH care services for individuals with mild to moderate mental illness or SUDs; to better manage total medical costs for individuals with co-occurring BH/PH conditions; and to improve health outcomes and beneficiary satisfaction. This portion of the amendment will eliminate the artificial service limits previously in place, align better with the intent of mental health parity, and eliminate restrictions on MCOs' ability to manage enrollees health care including BH.

## Implementation of the Demonstration

BH services using the delivery systems above will be implemented with the following phase-in schedules:

- Delaware DSAMH will issue requests for proposals (RFPs) and openly procure FFS contracts for providers of PROMISE benefits and care management as needed for adults meeting targeting and functional needs criteria to provide HCBS services under the PROMISE program for implementation no later than January 1, 2015.

- Delaware DMMA has already planned to re-procure their MCO contracts through an RFP. This re-procurement will include modifications to the contracts to provide BH for all adult populations as listed above.

# Demonstration Financing and Budget Neutrality

## Budget Neutrality Overview

This section presents the State's approach for showing budget neutrality for the amendment to Delaware's DSHP Section 1115(a) demonstration (demonstration) and the data and assumptions used in the development of the cost and caseload estimates supporting this 1115 waiver amendment request.

Budget neutrality estimates for this amendment request include expenditures for the PROMISE program. Estimates are also included for services related to crisis intervention, SUD treatment, and treatment by other licensed practitioners that were added to Delaware's state plan[11], effective July 1, 2014 but are not included within the budget neutrality agreement of the current demonstration. Additionally, estimates for psychiatrist services and anticipated utilization increases under the Delaware Medicaid MCO contracts have been included. Estimates for psychiatrist services are included to recognize the latent demand effect in relation to the availability of new HCBS, resulting in an increase in utilization of psychiatrists for medication management. New provisions under the MCO contracts will require the MCOs to cover all medically necessary BH care, effective January 1, 2015.

The proposed effective date of this amendment is January 1, 2015, subject to the CMS approval, through December 31, 2018, consistent with the remaining demonstration years of the current demonstration.

## Budget Neutrality Approach

This amendment request intends to add additional cost estimates related to the amendment programs and services to the applicable per member per month (PMPM) amounts in the budget neutrality agreement of the current demonstration. This amendment request does not propose to modify the manner in which the State is currently at risk for the per capita costs for demonstration eligibles (but not for the number of demonstration eligibles) under the budget neutrality agreement of the current demonstration.

As no new Medicaid populations are being added to the demonstration as a result of this amendment request, caseload estimates for the Medicaid eligibles in eligibility groups (EGs) within the current demonstration are assumed to be unchanged. As such, this amendment request intends to only add additional monies related to the amendment programs and services to the approved PMPMs of the current budget neutrality agreement using the same EG member months and growth rates applicable to the current demonstration. The results of this process and the adjusted PMPMs proposed by this amendment request are located in the summary of budget neutrality section below.

The impact of this amendment request is expected to be cost neutral in terms of budget neutrality. That is, cost estimates for this amendment are assumed to be the same for both without waiver costs and with waiver costs.

[11] State Plan Amendment (SPA) #13-0018 was submitted on December 16, 2013, and is still pending at the Centers for Medicare and Medicaid Services.

The State is assuming the budget neutrality agreement is in terms of total computable so that the State is not hindered by future changes to the federal medical assistance percentage rate on services.

## Methodology for Determining Budget Neutrality Estimates

This section provides background information about the methods and data sources used to develop the proposed 1115 waiver amendment estimates.

### Time Periods

Cost estimates for the waiver amendment request were developed for the last half of calendar year (CY) 2014 (July through December) and the full CY 2015. This was done to cleanly incorporate the six-month impact of the waiver amendment into the CY 2014 PMPMs of the current demonstration budget neutrality agreement and also incorporate a full twelve months of complete experience attributable to the amendment programs and services prior to trending the updated PMPMs to the later demonstration years. Once cost estimates for the waiver amendment are incorporated into the current demonstration PMPMs for CY 2015 and reflect a full twelve months of experience for the amendment programs and services, the adjusted PMPMs for each applicable eligibility group are trended forward to the remaining demonstration years (CY 2016 through CY 2018) using the growth rates of the approved demonstration.

### Waiver Eligibility Groups

Only the waiver eligibility groups expected to be impacted by the amendment request have been included in the tables and summaries below. Waiver eligibility group distributions applied to the cost estimates for each of the amendment programs and services are based on the estimated population/user mix of the respective program or service. Higher distributions for the Newly Eligible Group are due to the expectation that a large portion of the population within this group is expected to have the most latent demand and immediate needs for services under the Olmstead settlement. The majority of the waiver amendment programs and services are applicable to adults ages 18 years or older. The age cutoff for the adult and child eligibility groups within the budget neutrality agreement of the current demonstration is 21 years of age. The children eligibility groups include eligibles under the age of 21 years, and the adult eligibility groups include eligibles ages 21 years or older. Eligibility group distributions are identified alongside the applicable cost estimates for each amendment program and service in the section below.

### Cost Estimates

This section presents the sources and methodologies used for the estimates associated with each of the programs and services of this waiver amendment request.

#### *PROMISE*

It is estimated that by the end of CY 2014, approximately 4,300 Medicaid adults meeting targeting and functional needs criteria with severe and persistent mental illness and/or SUD will be served under the PROMISE program. Approximately 4,500 eligible adults are expected to be served in CY 2015. These counts are based on an analysis of recipients within the Delaware behavioral health system estimated to meet the eligibility requirements for the PROMISE program and trends consistent with the enrollment trends used for the current demonstration. The data used in this analysis covered various time periods within state fiscal year (SFY) 2013 and SFY 2014.

Budget neutrality cost estimates for the home and-community-based services (HCBS) included in the PROMISE program were developed using a combination of actual historical data and cost and

utilization data from other programs (Delaware and other states) with similar populations and services (for example, supportive employment costs). Program budget and expenditure reports from the Division of Substance Abuse and Mental Health (DSAMH) for services developed under the Department of Justice settlement and initially reimbursed out of all state funds (for example, peer support) were used to develop cost estimates for some PROMISE HCBS services. Data from these reports covered various time periods within SFY 2013 and SFY 2014 and was adjusted, as necessary, to reflect only those services and recipients' costs that will be eligible for Medicaid reimbursement under this amendment. For example, room and board costs were removed from the residential supports service cost estimates. For other services, Medicaid eligibility of the recipients was used to determine the portion of the total historical service costs that would be eligible for Medicaid funding. Costs for PROMISE program residential supports services already included within the budget neutrality agreement of the current demonstration were not included within the waiver amendment cost estimates.

Actual historical claims data obtained from the State's Medicaid Management Information Systems (MMIS) was also used in the development of cost estimates for some PROMISE HCBS services. However, because historical cost data for some PROMISE HCBS services was not easily or readily accessible or does not exist due to the particular service being new to the Delaware behavioral health population and having no historical experience, cost and utilization data from other programs with similar populations and services was also used to develop cost estimates (for example, supportive employment).

PROMISE HCBS service utilization estimates were determined using utilization data from other programs with similar populations and services, with some adjustments made to align estimated utilization with the particular service models of the PROMISE program. Adjustments were also made to utilization to reflect the number of PROMISE participants likely to use each of the PROMISE HCBS services and also account for any of the services not available to particular PROMISE participants because of limits on groups of services (for example, individuals receiving residential supports will not also receive personal care). These user adjustments were based on current and historical data that identified the services and programs within the Delaware behavioral health system utilized by those recipients estimated to be eligible to participate in the PROMISE program. For example, if a recipient was receiving assertive community treatment, intensive case management, or residential supports services, they were excluded from the utilization estimates of other PROMISE HCBS services where there would be duplication of services. For residential supports services, user estimates were determined through the use of current client counts known to the State.

The varying sources and applicable time periods of the data used to develop the PROMISE cost estimates eliminated the possibility for a single complete base period prior to the January 1, 2015, effective date of this amendment. When necessary, data was trended forward to the effective period of this amendment using trends consistent with the growth rates of the current demonstration. Note that in some instances, cost and utilization data from other sources was reflective of time periods within the effective dates of this amendment and did not require the application of trend. CY 2014 data was trended forward to CY 2015 using trends consistent with the growth rates of the current demonstration.

Eligibility group distributions for the PROMISE program are based on the estimated population/user mix of the respective program. The resulting cost impact to each applicable demonstration eligibility group is as follows:

**PROMISE Program Cost Estimates by Eligibility Group**

| Eligibility Group* | Eligibility Group Distribution | CY 2014 (Jul–Dec) | CY 2015 |
|---|---|---|---|
| DSHP TANF Children | 0.4% | $110,568 | $246,077 |
| DSHP TANF Adults | 12.5% | $3,768,538 | $8,387,134 |
| DSHP SSI Children | 0.5% | $147,424 | $328,103 |
| DSHP SSI Adults | 22.0% | $6,652,530 | $14,805,649 |
| DSHP-Plus State Plan | 17.4% | $5,261,211 | $11,709,177 |
| Newly Eligible Group | 47.2% | $14,235,676 | $31,682,448 |
| Total | 100.0% | $30,175,948 | $67,158,588 |

*Children (ages 20 years or under), Adults (ages 21 years or older)

### *Added SPA Services*

Estimates are included for services related to crisis intervention, SUD treatment, and treatment by other licensed practitioners. These services were added to Delaware's state plan, effective July 1, 2014 (see footnote 1 on page 1), but are not included within the budget neutrality agreement of the current demonstration. Estimates for these services were developed using various data sources, including program budget and expenditure reports from DSAMH and provider cost reports adjusted for Medicaid allowable amounts. Data was trended forward to the effective period of this amendment using trends consistent with the growth rates of the current demonstration.

Eligibility group distributions for the SPA services are based on the estimated population/user mix of the respective services. The resulting cost impact to each applicable demonstration eligibility group is as follows:

**Added SPA Services Cost Estimates by Eligibility Group**

| Eligibility Group* | Eligibility Group Distribution | CY 2014 (Jul–Dec) | CY 2015 |
|---|---|---|---|
| DSHP TANF Children | 0.4% | $48,284 | $101,277 |
| DSHP TANF Adults | 12.5% | $1,645,696 | $3,451,855 |
| DSHP SSI Children | 0.5% | $64,379 | $135,036 |
| DSHP SSI Adults | 22.0% | $2,905,116 | $6,093,495 |
| DSHP-Plus State Plan | 17.4% | $2,297,536 | $4,819,094 |
| Newly Eligible Group | 47.2% | $6,216,626 | $13,039,405 |
| Total | 100.0% | $13,177,639 | $27,640,163 |

*Children (ages 20 years or under), Adults (ages 21 years or older)

### *Psychiatrist Services*

Estimates for psychiatrist services are included to recognize the latent demand effect in relation to the availability of new 1915(i)-like services, resulting in an increase in utilization of psychiatrists for medication management. Estimates were based on the State's SFY 2013 program data and trended forward using growth rates consistent with the current demonstration.

Eligibility group distributions for the psychiatrist services are based on the estimated population/user mix of the services. The resulting cost impact to each applicable eligibility group is as follows:

**Psychiatrist Services Cost Estimates by Eligibility Group**

| Eligibility Group* | Eligibility Group Distribution | CY 2014 (Jul–Dec) | CY 2015 |
|---|---|---|---|
| DSHP TANF Children | 0.4% | $2,152 | $4,518 |
| DSHP TANF Adults | 12.5% | $73,331 | $153,994 |
| DSHP SSI Children | 0.5% | $2,869 | $6,024 |
| DSHP SSI Adults | 22.0% | $129,449 | $271,843 |
| DSHP-Plus State Plan | 17.4% | $102,376 | $214,990 |
| Newly Eligible Group | 47.2% | $277,007 | $581,715 |
| Total | 100.0% | $587,183 | $1,233,084 |

*Children (ages 20 years or under), Adults (ages 21 years or older)

### *DSHP Behavioral Health Benefit Under the Delaware MCO Contracts*

Estimates for this waiver amendment are included to account for the impact of providing a comprehensive behavioral health benefit within DSHP under the MCO contracts, where MCOs will be required to cover all medically necessary behavioral health care, effective January 1, 2015. Estimates were developed using Delaware Medicaid managed care capitation rate setting data for behavioral health services. This data was adjusted for expected utilization increases and cost trends consistent with the program change adjustments used in the development of capitation rates for the CY 2015 contract period.

Eligibility group distributions for the increased utilization of behavioral health services due to the impact of providing a comprehensive behavioral health benefit within DSHP under the MCO contracts are based on the population mix of the individual rate tiers applicable to the managed care capitation rate program change adjustment for this item. The resulting cost impact to each applicable eligibility group is as follows:

**DSHP BH Benefit Under the MCO Contracts Cost Estimates by Eligibility Group**

| Eligibility Group* | Eligibility Group Distribution | CY 2014 (Jul–Dec) | CY 2015 |
|---|---|---|---|
| DSHP TANF Children | 1.3% | $0 | $32,879 |
| DSHP TANF Adults | 15.5% | $0 | $400,524 |
| DSHP SSI Children | 0.5% | $0 | $13,781 |
| DSHP SSI Adults | 15.2% | $0 | $392,305 |
| DSHP-Plus State Plan | 1.9% | $0 | $49,819 |
| Newly Eligible Group | 65.5% | $0 | $1,690,723 |
| Total | 100.0% | $0 | $2,580,030 |

*Children (ages 20 years or under), Adults (ages 21 years or older)

### *Total Waiver Amendment Programs and Services*

The total CY 2014 (Jul–Dec) and CY 2015 estimates for the waiver amendment programs and services detailed above are as follows:

**Total Amendment Program and Services Cost Estimates by Eligibility Group**

| Eligibility Group* | Eligibility Group Distribution | CY 2014 (Jul–Dec) | CY 2015 |
|---|---|---|---|
| DSHP TANF Children | 0.4% | $161,004 | $384,751 |
| DSHP TANF Adults | 12.5% | $5,487,565 | $12,393,507 |
| DSHP SSI Children | 0.5% | $214,672 | $482,944 |
| DSHP SSI Adults | 21.9% | $9,687,095 | $21,563,292 |
| DSHP-Plus State Plan | 17.2% | $7,661,123 | $16,793,080 |
| Newly Eligible Group | 47.5% | $20,729,309 | $46,994,291 |
| Total | 100.0% | $43,940,769 | $98,611,865 |

*Children (ages 20 years or under), Adults (ages 21 years or older)

## Summary of Budget Neutrality

This section presents a summary of the waiver amendment estimates in the tables below. Table A details the process for incorporating adjustments into the current demonstration PMPMs, the resulting adjusted PMPMs proposed by this amendment request, and the estimated five-year dollar impact of the waiver amendment request. Table B details the without-waiver and with-waiver dollar impact of the amendment adjustments. Because the services included in this amendment request could be offered under the state plan in the absence of the waiver, costs attributable to the waiver amendment request are assumed to be the same for both the without-waiver estimates and the with-waiver estimates. Note that all amounts in the tables below are presented on a total share basis and reflect both state and federal share of expenditures.

# Table A

**Diamond State Health Plan 1115 Demonstration Waiver Amendment Expenditure Estimates**
**And Current Demonstration Budget Neutrality Impact Summary**
**Total Share**

**A. Total Estimate for Amendment Programs and Services**

| Eligibility Group[1] | Distribution | DY 19[2] | DY 20 | DY 21 | DY 22 | DY 23 | Total |
|---|---|---|---|---|---|---|---|
| DSHP TANF Children | 0.4% | $ 161,004 | $ 384,751 | | | | $ 545,756 |
| DSHP TANF Adult | 12.5% | $ 5,487,565 | $ 12,393,507 | | | | $ 17,881,072 |
| DSHP SSI Children | 0.5% | $ 214,672 | $ 482,944 | | | | $ 697,617 |
| DSHP SSI Adults | 21.9% | $ 9,687,095 | $ 21,563,292 | | | | $ 31,250,387 |
| DSHP-Plus State Plan | 17.2% | $ 7,661,123 | $ 16,793,080 | | | | $ 24,454,203 |
| Newly Eligible Group | 47.5% | $ 20,729,309 | $ 46,994,291 | | | | $ 67,723,600 |
| Total | 100.0% | $ 43,940,769 | $ 98,611,865 | | | | $ 142,552,634 |

**B. Current Demonstration Approved PMPMs and Growth Rates**

| Eligibility Group[1] | Growth Rate | DY 19 | DY 20 | DY 21 | DY 22 | DY 23 | Total |
|---|---|---|---|---|---|---|---|
| DSHP TANF Children | 5.00% | $ 413.82 | $ 434.51 | $ 456.24 | $ 479.05 | $ 503.00 | |
| DSHP TANF Adult | 5.16% | $ 685.11 | $ 720.46 | $ 757.64 | $ 796.73 | $ 837.84 | |
| DSHP SSI Children | 5.00% | $ 2,360.45 | $ 2,478.47 | $ 2,602.39 | $ 2,732.51 | $ 2,869.14 | |
| DSHP SSI Adults | 4.50% | $ 2,404.12 | $ 2,512.31 | $ 2,625.36 | $ 2,743.50 | $ 2,866.96 | |
| DSHP-Plus State Plan | 2.76% | $ 2,528.14 | $ 2,597.92 | $ 2,669.62 | $ 2,743.30 | $ 2,819.02 | |
| Newly Eligible Group | 5.10% | $ 463.14 | $ 486.76 | $ 511.58 | $ 537.68 | $ 565.10 | |

**C. Member Month Projections for Approved Demonstration**

| Eligibility Group[1] | DY 19[2] | DY 20 | DY 21 | DY 22 | DY 23 | Total |
|---|---|---|---|---|---|---|
| DSHP TANF Children | 534,509 | 1,106,433 | 1,145,158 | 1,173,787 | 1,203,132 | |
| DSHP TANF Adult | 226,332 | 475,297 | 499,061 | 512,037 | 525,350 | |
| DSHP SSI Children | 34,222 | 69,471 | 70,513 | 71,923 | 73,361 | |
| DSHP SSI Adults | 41,915 | 87,184 | 90,671 | 92,575 | 94,519 | |
| DSHP-Plus State Plan | 51,949 | 105,976 | 108,096 | 111,555 | 115,125 | |
| Newly Eligible Group | 285,534 | 632,078 | 691,196 | 725,756 | 762,044 | |

**D. Current Demonstration Dollars: Current Demonstration Approved PMPMs x Member Months (B x C)**

| Eligibility Group[1] | DY 19[2] | DY 20 | DY 21 | DY 22 | DY 23 | Total |
|---|---|---|---|---|---|---|
| DSHP TANF Children | $ 221,190,514 | $ 480,756,203 | $ 522,466,886 | $ 562,302,662 | $ 605,175,396 | $ 2,391,891,661 |
| DSHP TANF Adult | $ 155,061,974 | $ 342,432,477 | $ 378,108,576 | $ 407,955,239 | $ 440,159,244 | $ 1,723,717,510 |
| DSHP SSI Children | $ 80,779,320 | $ 172,181,789 | $ 183,502,326 | $ 196,530,317 | $ 210,482,980 | $ 843,476,732 |
| DSHP SSI Adults | $ 100,768,690 | $ 219,033,235 | $ 238,044,017 | $ 253,979,513 | $ 270,982,192 | $ 1,082,807,646 |
| DSHP-Plus State Plan | $ 131,334,345 | $ 275,317,170 | $ 288,575,244 | $ 306,028,832 | $ 324,539,678 | $ 1,325,795,267 |
| Newly Eligible Group | $ 132,242,217 | $ 307,670,287 | $ 353,602,050 | $ 390,224,486 | $ 430,631,064 | $ 1,614,370,104 |
| Total | $ 821,377,060 | $ 1,797,391,161 | $ 1,964,299,098 | $ 2,117,021,048 | $ 2,281,970,554 | $ 8,982,058,920 |

**E. DY 19 (Jul-Dec) & DY 20 Adjusted Demonstration Dollars: Current Demonstration Dollars + Amendment Costs (A + D)**

| Eligibility Group[1] | DY 19[2] | DY 20 | DY 21 | DY 22 | DY 23 | Total |
|---|---|---|---|---|---|---|
| DSHP TANF Children | $ 221,351,519 | $ 481,140,954 | | | | $ 702,492,473 |
| DSHP TANF Adult | $ 160,549,539 | $ 354,825,983 | | | | $ 515,375,522 |
| DSHP SSI Children | $ 80,993,992 | $ 172,664,734 | | | | $ 253,658,726 |
| DSHP SSI Adults | $ 110,455,785 | $ 240,596,527 | | | | $ 351,052,312 |
| DSHP-Plus State Plan | $ 138,995,468 | $ 292,110,249 | | | | $ 431,105,718 |
| Newly Eligible Group | $ 152,971,526 | $ 354,664,578 | | | | $ 507,636,104 |
| Total | $ 865,317,829 | $ 1,896,003,026 | | | | $ 2,761,320,855 |

**F. Adjusted Demonstration PMPMs**

| Eligibility Group[1] | Growth Rate (GR) | DY 19 (E / C) | DY 20 (E / C) | DY 21 (DY 20 x GR) | DY 22 (DY 21 x GR) | DY 23 (DY 22 x GR) | Total |
|---|---|---|---|---|---|---|---|
| DSHP TANF Children | 5.00% | $ 414.12 | $ 434.86 | $ 456.60 | $ 479.43 | $ 503.40 | |
| DSHP TANF Adult | 5.16% | $ 709.36 | $ 746.54 | $ 785.06 | $ 825.57 | $ 868.16 | |
| DSHP SSI Children | 5.00% | $ 2,366.72 | $ 2,485.42 | $ 2,609.69 | $ 2,740.18 | $ 2,877.19 | |
| DSHP SSI Adults | 4.50% | $ 2,635.23 | $ 2,759.64 | $ 2,883.82 | $ 3,013.60 | $ 3,149.21 | |
| DSHP-Plus State Plan | 2.76% | $ 2,675.61 | $ 2,756.38 | $ 2,832.46 | $ 2,910.63 | $ 2,990.97 | |
| Newly Eligible Group | 5.10% | $ 535.74 | $ 561.11 | $ 589.73 | $ 619.80 | $ 651.41 | |

**G. Adjusted Demonstration Dollars: Adjusted Demonstration PMPMs x Member Months (C x F)**

| Eligibility Group[1] | DY 19[2] | DY 20 | DY 21 | DY 22 | DY 23 | Total |
|---|---|---|---|---|---|---|
| DSHP TANF Children | $ 221,351,519 | $ 481,140,954 | $ 522,879,861 | $ 562,749,474 | $ 605,659,285 | $ 2,393,781,093 |
| DSHP TANF Adult | $ 160,549,539 | $ 354,825,983 | $ 391,791,087 | $ 422,720,044 | $ 456,090,274 | $ 1,785,976,927 |
| DSHP SSI Children | $ 80,993,992 | $ 172,664,734 | $ 184,017,270 | $ 197,081,784 | $ 211,073,267 | $ 845,831,048 |
| DSHP SSI Adults | $ 110,455,785 | $ 240,596,527 | $ 261,479,268 | $ 278,983,723 | $ 297,660,052 | $ 1,189,175,355 |
| DSHP-Plus State Plan | $ 138,995,468 | $ 292,110,249 | $ 306,177,302 | $ 324,695,675 | $ 344,335,026 | $ 1,406,313,721 |
| Newly Eligible Group | $ 152,971,526 | $ 354,664,578 | $ 407,615,860 | $ 449,824,606 | $ 496,404,074 | $ 1,861,480,643 |
| Total | $ 865,317,829 | $ 1,896,003,026 | $ 2,073,960,647 | $ 2,236,055,307 | $ 2,411,221,979 | $ 9,482,558,788 |

**H. Impact of Amendment Costs: Adjusted Demonstration Dollars - Current Demonstration Dollars (G - D)**

| Eligibility Group[1] | DY 19[2] | DY 20 | DY 21 | DY 22 | DY 23 | Total |
|---|---|---|---|---|---|---|
| DSHP TANF Children | $ 161,004 | $ 384,751 | $ 412,975 | $ 446,812 | $ 483,889 | $ 1,889,432 |
| DSHP TANF Adult | $ 5,487,565 | $ 12,393,507 | $ 13,682,511 | $ 14,764,805 | $ 15,931,030 | $ 62,259,418 |
| DSHP SSI Children | $ 214,672 | $ 482,944 | $ 514,944 | $ 551,467 | $ 590,288 | $ 2,354,316 |
| DSHP SSI Adults | $ 9,687,095 | $ 21,563,292 | $ 23,435,251 | $ 25,004,210 | $ 26,677,860 | $ 106,367,708 |
| DSHP-Plus State Plan | $ 7,661,123 | $ 16,793,080 | $ 17,602,058 | $ 18,666,844 | $ 19,795,349 | $ 80,518,454 |
| Newly Eligible Group | $ 20,729,309 | $ 46,994,291 | $ 54,013,810 | $ 59,600,120 | $ 65,773,010 | $ 247,110,539 |
| Total | $ 43,940,769 | $ 98,611,865 | $ 109,661,550 | $ 119,034,258 | $ 129,251,425 | $ 500,499,867 |

**Notes:**

1. Eligibility groups are based on Delaware's DSHP approved Section 1115(a) demonstration. Only eligibility groups impacted by this amendment request have been included in this analysis. TANF & SSI children eligibility groups include enrollees under 21 years of age. TANF & SSI adult eligibility groups include enrollees 21 years of age or older. Newly eligible group: up to 133% FPL.
2. | DY 19: CY 2014 (July - December) | DY 20: CY 2015 | DY 21: CY 2016 | DY 22: CY 2017 | DY 23: CY 2018 |

# Table B

**Diamond State Health Plan 1115 Demonstration Waiver Amendment Expenditure Estimates**
**Budget Neutrality Summary for Waiver Amendment Programs and Services**

**Waiver Amendment Programs and Services Dollars Only**
**Total Share**

**Without-Waiver Expenditure Estimates**

| Eligibility Group[1] | DY 19[2] (CY 2014 Jul-Dec) | DY 20 (CY 2015) | DY 21 (CY 2016) | DY 22 (CY 2017) | DY 23 (CY 2018) | Total |
|---|---|---|---|---|---|---|
| Mandatory and Optional State Plan Groups | | | | | | |
| DSHP TANF Children | $ 161,004 | $ 384,751 | $ 412,975 | $ 446,812 | $ 483,889 | $ 1,889,432 |
| DSHP TANF Adult | $ 5,487,565 | $ 12,393,507 | $ 13,682,511 | $ 14,764,805 | $ 15,931,030 | $ 62,259,418 |
| DSHP SSI Children | $ 214,672 | $ 482,944 | $ 514,944 | $ 551,467 | $ 590,288 | $ 2,354,316 |
| DSHP SSI Adults | $ 9,687,095 | $ 21,563,292 | $ 23,435,251 | $ 25,004,210 | $ 26,677,860 | $ 106,367,708 |
| DSHP-Plus State Plan | $ 7,661,123 | $ 16,793,080 | $ 17,602,058 | $ 18,666,844 | $ 19,795,349 | $ 80,518,454 |
| Hypothetical Populations | | | | | | |
| Newly Eligible Group | $ 20,729,309 | $ 46,994,291 | $ 54,013,810 | $ 59,600,120 | $ 65,773,010 | $ 247,110,539 |
| Total | $ 43,940,769 | $ 98,611,865 | $ 109,661,550 | $ 119,034,258 | $ 129,251,425 | $ 500,499,867 |

**With-Waiver Expenditure Estimates**

| Eligibility Group[1] | DY 19[2] (CY 2014 Jul-Dec) | DY 20 (CY 2015) | DY 21 (CY 2016) | DY 22 (CY 2017) | DY 23 (CY 2018) | Total |
|---|---|---|---|---|---|---|
| Mandatory and Optional State Plan Groups | | | | | | |
| DSHP TANF Children | $ 161,004 | $ 384,751 | $ 412,975 | $ 446,812 | $ 483,889 | $ 1,889,432 |
| DSHP TANF Adult | $ 5,487,565 | $ 12,393,507 | $ 13,682,511 | $ 14,764,805 | $ 15,931,030 | $ 62,259,418 |
| DSHP SSI Children | $ 214,672 | $ 482,944 | $ 514,944 | $ 551,467 | $ 590,288 | $ 2,354,316 |
| DSHP SSI Adults | $ 9,687,095 | $ 21,563,292 | $ 23,435,251 | $ 25,004,210 | $ 26,677,860 | $ 106,367,708 |
| DSHP-Plus State Plan | $ 7,661,123 | $ 16,793,080 | $ 17,602,058 | $ 18,666,844 | $ 19,795,349 | $ 80,518,454 |
| Hypothetical Populations | | | | | | |
| Newly Eligible Group | $ 20,729,309 | $ 46,994,291 | $ 54,013,810 | $ 59,600,120 | $ 65,773,010 | $ 247,110,539 |
| Total | $ 43,940,769 | $ 98,611,865 | $ 109,661,550 | $ 119,034,258 | $ 129,251,425 | $ 500,499,867 |

**Variance[3]**
**(Without-Waiver Expenditures Less With-Waiver Expenditures)**

| | DY 19[2] (CY 2014 Jul-Dec) | DY 20 (CY 2015) | DY 21 (CY 2016) | DY 22 (CY 2017) | DY 23 (CY 2018) | Total |
|---|---|---|---|---|---|---|
| Mandatory and Optional State Plan Groups | $ - | $ - | $ - | $ - | $ - | $ - |
| Hypothetical Populations | $ - | $ - | $ - | $ - | $ - | $ - |
| Total | $ - | $ - | $ - | $ - | $ - | $ - |

**Notes:**

1. Eligibility groups are based on Delaware's DSHP approved Section 1115(a) demonstration. Only eligibility groups impacted by this amendment request have been included in this analysis. TANF & SSI children eligibility groups include enrollees under 21 years of age. TANF & SSI adult eligibility groups include enrollees 21 years of age or older. Newly eligible group: up to 133% FPL.
2. DY 19 dollars reflect the last six months of calendar year 2014 (July through December) in order to align with the effective date of the 1115 waiver amendment.
3. Because the services included in this amendment request could be offered under the state plan in the absence of the waiver, costs attributable to the waiver amendment request are assumed to be the same for both the without-waiver estimates and the with-waiver estimates.

## List of Proposed Waivers and Expenditure Authorities

1. **Amount, Duration, and Scope Section (Comparability) 1902(a)(10)(B)**
   To the extent necessary to enable the State to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, by providing additional services to enrollees in certain targeted programs to provide HCBS.

2. **Freedom of Choice Section 1902(a)(23)(A)**
   To the extent necessary, to enable the State to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans for the receipt of covered services and selective contracting of FFS providers, including HCBS services such as contracting with providers and a transportation broker for non-medical transportation. No waiver of freedom of choice is authorized for family planning providers or emergency providers.

## Public Process and Notice

The State has been working to comply with the Olmstead settlement since signature of that agreement on July 6, 2011 and the order on July 15, 2011. Status on the implementation of the settlement can be found at: http://www.ada.gov/olmstead/olmstead_cases_list2.htm.

The State will work with stakeholders to ensure that impacted participants, providers and advocates are informed in a timely manner regarding all changes to the system.

The proposed amendment will be placed on public notice on September 1, 2014 for 30 days. The amendment will incorporate changes and suggestions by the public from that process.

# Attachment A

## PROMISE (BH HCBS program) Service Definitions

| HCBS Service | Service Definition |
|---|---|
| Care management (CM) | CM includes services assisting beneficiaries in gaining access to needed demonstration and other State Plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Care managers are responsible for the ongoing monitoring of the provision of services included in the beneficiary's Recovery Plan and/or beneficiary health and welfare. Care managers are responsible for initiating the process to evaluate and/or re-evaluate the beneficiary's level of care/needs-based eligibility and/or development of Recovery Plans. Care managers are responsible for assisting the beneficiary in gaining access to needed services regardless of the funding source.<br><br>The care manager provides intensive CM for PROMISE members in need of supports services through service planning and coordination to identify services; brokering of services to obtain and integrate services, facilitation, and advocacy to resolve issues that impede access to needed services; monitoring and reassessment of services based on changes in member's condition; and gate keeping to assess and determine the need for services to members.<br><br>In the performance of providing information to beneficiaries, the care manager will:<br>• Inform beneficiaries about the HCBS, required needs assessments, the person-centered planning process, service alternatives, service delivery options (opportunities for beneficiary-direction), roles, rights, risks, and responsibilities.<br>• Inform beneficiaries on fair hearing rights and assist with fair hearing requests when needed and upon request.<br><br>In the performance of facilitating access to needed services and supports, the care manager will:<br>• Collect additional necessary information including, at a minimum, beneficiary preferences, strengths, and goals to inform the development of the beneficiary-centered Recovery Plan.<br>• Assist the beneficiary and his/her service planning team in identifying and choosing willing and qualified providers.<br>• Coordinate efforts and prompt the beneficiary to ensure the completion of activities necessary to maintain HCBS program eligibility.<br><br>In the performance of the coordinating function, the care manager will:<br>• Coordinate efforts in accordance with department requirements and prompt the beneficiary to participate in the completion of a needs assessment as required by the State to identify appropriate levels of need and to serve as the foundation for the development of and updates to the Recovery Plan.<br>• Use a person-centered planning approach and a team process which may include peer care managers to develop the beneficiary's Recovery Plan to meet the beneficiary's needs in the least restrictive manner possible. At a minimum, the approach shall:<br>— Include people chosen by the beneficiary for Recovery Plan meetings, review assessments, include discussion of needs, to gain understanding of the beneficiary's preferences, suggestions for services, and other activities key to ensure a beneficiary-centered Recovery Plan.<br>— Provide necessary information and support to ensure that the beneficiary directs the process to the maximum extent possible and is enabled to make informed choices and decisions.<br>— Be timely and occur at times and locations of convenience to the beneficiary; reflect cultural considerations of the beneficiary. |

| HCBS Service | Service Definition |
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| CM (cont'd) | – Include strategies for solving conflict or disagreement within the process.<br>– Offer choices to the beneficiary regarding the services and supports they receive and the providers who may render them.<br>– Inform beneficiaries of the method to request updates to the Recovery Plan.<br>– Ensure and document the beneficiary's participation in the development of the Recovery Plan.<br>• Develop and update the Recovery Plan in accordance with the State requirements based upon the standardized needs assessment and person-centered planning process annually, or more frequently as needed.<br>• Explore coverage of services to address beneficiary identified needs through other sources, including services provided under the State Plan, Medicare, and/or private insurance or other community resources. These resources shall be used until the plan limitations have been reached or a determination of non-coverage has been established and prior to any service's inclusion in the Recovery Plan, in accordance with department standards.<br>• Actively coordinate with other individuals and/or entities essential in the physical and/or behavioral care delivery for the beneficiary, including MCO care coordinators, to ensure seamless coordination between physical, behavioral, and support services.<br>• Coordinate with providers and potential providers of services to ensure seamless service access and delivery.<br>• Coordinate with the beneficiary's family, friends, and other community members to cultivate the beneficiary's natural support network, to the extent that the beneficiary (adult) has provided permission for such coordination.<br>In the performance of the monitoring function, the care manager will:<br>• Monitor the health, welfare, and safety of the beneficiary and Recovery Plan implementation through regular contacts (monitoring visits with the beneficiary, paid and unpaid caregivers, and others) at a minimum frequency as required by the department.<br>• Respond to and assess emergency situations and incidents and assure that appropriate actions are taken to protect the health, welfare, and safety of the beneficiary.<br>• Review provider documentation of service provision and monitor beneficiary progress on outcomes and initiate Recovery Plan team discussions or meetings when services are not achieving desired outcomes. Outcomes include housing status, employment status, involvement in the criminal justice system, response to treatment, and other services, and satisfaction with services.<br>• Through the Recovery Plan monitoring process, solicit input from beneficiary and/or family, as appropriate, related to satisfaction with services.<br>• Arrange for modifications in services and service delivery, as necessary, to address the needs of the beneficiary, consistent with an assessment of need and department requirements, and modify the Recovery Plan accordingly.<br>• Advocate for continuity of services, system flexibility and integration, proper utilization of facilities and resources, accessibility and beneficiary rights.<br>• Participate in any department identified activities related to quality oversight.<br>The maximum caseload for a care manager providing services through this waiver is set by Medicaid or its designee, which includes individuals in other waiver programs and other funding sources, unless the requirement is waived by the department.<br>CM agencies must use an information system as approved and required by the department to maintain case records in accordance with department requirements. |

| HCBS Service | Service Definition |
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| Benefits Counseling | Benefits Counseling provides work incentive counseling services to PROMISE participants seeking to work while maintaining access to necessary healthcare and other benefits. Benefits counseling will provide information to individuals regarding available benefits and assist individuals to understand options for making an informed choice about going to work while maintaining essential benefits. This service will assist individuals to understand the work incentives and support programs available and the impact of work activity on those benefits. This service will assist individuals to understand their benefits supports and how to utilize work incentives and other tools to assist them to achieve self-sufficiency through work. This service will also include the development and maintenance of proper documentation of services, including creating Benefits Summaries and Analyses and Work Incentive Plans. Services must be delivered in a manner that supports the participant's communication needs including, but not limited to, age appropriate communication, translation/interpretation services for participants that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding and use of communication devices used by the participant. |
| Community psychiatric support and treatment (CPST) | CPST services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid eligible adults with significant functional impairments meeting the need levels in the PROMISE program resulting from an identified mental health or substance abuse disorder diagnosis. The medical necessity for these treatment and rehabilitative services must be determined by a licensed behavioral health practitioner (LBHP) or physician who is acting within the scope of his/her professional license and applicable state law and furnished by or under the direction of a licensed practitioner, to promote the maximum reduction of symptoms and/or restoration of a beneficiary to his/her best age-appropriate functional level. The LBHP or physician may conduct an assessment consistent with state law, regulation, and policy. A unit of service is defined according to the healthcare common procedure coding system (HCPCS) approved code set unless otherwise specified.<br><br>**Definitions:**<br><br>The services are defined as follows:<br><br>• CPST are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the beneficiary's Recovery Plan. CPST is a face-to-face intervention with the beneficiary present; however, family or other collaterals may also be involved. This service may include the following components:<br>— Assist the beneficiary and family members or other collaterals to identify strategies or treatment options associated with the beneficiary's mental illness and/or SUD, with the goal of minimizing the negative effects of symptoms or emotional disturbances or associated environmental stressors which interfere with the beneficiary's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.<br>— Provide beneficiary supportive counseling, solution-focused interventions, emotional and behavioral management support, and behavioral analysis with the beneficiary, with the goal of assisting the beneficiary with developing and implementing social, interpersonal, self-care, daily living, and independent living skills to restore stability, to support functional gains, and to adapt to community living.<br>— Facilitate participation in and utilization of strengths-based planning and treatments, which include assisting the beneficiary and family members or other collaterals with identifying strengths and needs, resources, natural supports, and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their mental illness and/or SUD. |

| HCBS Service | Service Definition |
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| CPST (cont'd) | — Assist the beneficiary with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the beneficiary and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or as appropriate, seeking other supports to restore stability and functioning.<br>— Provide restoration, rehabilitation, and support to develop skills to locate, rent, and keep a home, to enable landlord/tenant negotiations; to select a roommate and to understand and exercise renter's rights and responsibilities.<br>— Assist the beneficiary to develop daily living skills specific to managing their own home including managing their money, medications, and using community resources and other self-care requirements.<br>— Implement interventions using evidence-based techniques, drawn from cognitive-behavioral therapy and other evidence-based psychotherapeutic interventions that ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom manifestation. |
| Community-based residential alternatives supports that exclude assisted living | Community-based residential supports (excluding assisted living) offer a cost-effective, community-based alternative to institutional levels of care for persons with BH needs. Community-based residential services are supportive and health-related residential services provided to beneficiaries in settings licensed by the State. Residential services are necessary, as specified in the Recovery Plan, to enable the beneficiary to remain integrated in the community and ensure the health, welfare, and safety of the beneficiary. Community-based residential services include personal care and supportive services (homemaker, chore, attendant services, and meal preparation) that are furnished to beneficiaries who reside in homelike, non-institutional, integrated settings. In addition, they include 24-hour onsite response capability to meet scheduled and unscheduled or unpredictable beneficiary needs to provide supervision and safety. Services also include social and recreational programming, and medication assistance (to the extent permitted under State law).<br>This service includes assisting beneficiaries in acquiring, retaining, and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside successfully in home and community-based settings. As needed, this service may also include prompting to carry out desired behaviors and/or to curtail inappropriate behaviors as well as habilitative services to instruct beneficiaries in accessing and using community resources such as transportation, translation, and communication assistance related to a habilitative outcome and services to assist the beneficiary in shopping and other necessary activities of community and civic life, including self advocacy. Finally, assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) are included. This service will be provided to meet the beneficiary's needs as determined by an assessment performed in accordance with department requirements and as outlined in the beneficiary's Recovery Plan.<br>ADLs include tasks related to caring for and moving the body. ADLs include:<br>• Walking.<br>• Bathing.<br>• Dressing.<br>• Toileting.<br>• Brushing teeth.<br>• Eating. |

| HCBS Service | Service Definition |
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| Community-based residential alternatives supports that exclude assisted living (cont'd) | IADLs are the activities that people do once they are up, dressed, put together. IADLs are an additional set of more complex life functions necessary for maintaining a person's immediate environment and living independently in the community. IADLs include:<br>• Cooking.<br>• Performing ordinary housework.<br>• Getting around in the community.<br>• Using the telephone or computer.<br>• Shopping for groceries.<br>• Supporting the beneficiary in exploring employment opportunities<br>• Keeping track of finances.<br>Managing medication. (Not appropriate for Peer Specialists.)The provider will be encouraged to hire staff to deliver personal care services separate from staff who provide habilitation services that involved the development of ADL and IADL skills, if there is more than one staff member on site at the residence during normal hours, who can provide personal care services. This will ensure that the clinical boundary issues that would otherwise complicate habilitation services (if the same staff were also delivering personal care services) will be mitigated.<br>Services must be delivered in a manner that supports the beneficiary's communication needs including, but not limited to age appropriate communication, translation services for beneficiaries that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding and use of communication devices used by the beneficiary.<br>The cost of transportation provided by residential service providers to and from activities is included as a component of the residential services and; therefore, is reflected in the rate for the service. Providers of residential services are responsible for the full range of transportation services needed by the beneficiaries they serve to participate in services and activities specified in their Recovery Plan. This includes transportation to and from daily activities and employment services, as applicable.<br>The following levels of residential services are available to beneficiaries as determined necessary, based upon a quarterly assessment, documented in the Recovery Plan and approved by the department.<br>Model 1 — habilitative supports in the home (the beneficiary is encouraged to seek BH treatment for SPMI in the community) (Tiers 1 and 2).<br>**Tier 1: A beneficiary requires:**<br>• Limited supervision as the beneficiary is able to make safe decisions when in familiar surroundings, but requires occasional increased need for assistance or to address unanticipated needs, with supports available on a 24-hour on call or as-needed basis.<br>• Incidental or intermittent hands-on assistance or cueing for at least one ADL and at least one IADL.<br>• Incidental or intermittent hands-on assistance or cueing with at least three IADLs.<br>• Instruction in accessing and using community resources such as transportation, translation, and communication assistance related to a habilitative outcome and services to assist the beneficiary in shopping and other necessary activities of community and civic life, including self-advocacy. Instruction in developing or maintaining financial stability and security (e.g., understanding budgets, managing money, and the right to manage their own money). |

| HCBS Service | Service Definition |
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| Community-based residential alternatives supports that exclude assisted living (cont'd) | **Tier 2: A beneficiary requires:**<br>• Low intensity supervision with staff on site or available to ensure safety from harm as determined by an assessment.<br>• Unsupervised care depending on the assessment and the Recovery Plan.<br>• Management of one or more behaviors that prevent or interfere with the beneficiary's inclusion in home and family life or community life.<br>• Hands-on assistance or cueing for at least two ADLs.<br>• Hands-on assistance or cueing with at least four IADLs. Instruction in accessing and using community resources such as transportation, translation, and communication assistance related to a habilitative outcome and services to assist the beneficiary in shopping and other necessary activities of community and civic life, including self-advocacy.<br>• Instruction in developing or maintaining financial stability and security (e.g., understanding budgets, managing money, and the right to manage their own money).<br>Model 2 — intensive supports for medically fragile beneficiaries (Tiers 3 and 4).<br>**Tier 3: A beneficiary requires:**<br>• Supervision with staff on site to ensure safety from harm as determined by an assessment.<br>• Intermittent skilled care of a licensed professional or paraprofessional throughout the day for medical diagnosis or medical treatment.<br>• Management of one or more behaviors of a disruptive or destructive nature that prevent or interfere with the beneficiary's inclusion in home and family life or community life.<br>• Hands-on assistance or cueing with at least two ADLs or periodic assistance throughout a day with at least three ADLs.<br>• Complete assistance with at least four IADLs.<br>Special care unit services.<br>**Tier 4: A beneficiary requires:**<br>• Extensive support and cannot be left alone for any period throughout the day, as determined by an assessment or clinical determination of need for continuous supervision, due to a significant risk for recent or ongoing occurrences of behavior in which the beneficiary is a threat to self or others.<br>• The service provider must maintain documentation in accordance with department requirements. The documentation must be available to the care manager for monitoring at all times on an ongoing basis. The care manager will review the authorized tier on an ongoing basis and monitor the community character of the residence during regularly scheduled contact with the beneficiary. Results of this monitoring will be reported to the department. If the monitoring suggests that a change in tiers is needed, the care manager will recommend a re-assessment to re-evaluate the beneficiary to determine the appropriateness of the assigned tier in accordance with department requirements. |

| HCBS Service | Service Definition |
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| Financial coaching | Financial Coaching Plus uses a financial coaching model to assist individuals in establishing financial goals, creating a plan to achieve them, and providing information, support, and resources needed to implement stated goals in the financial plan. The financial coach will assist the client seeking to improve his/her financial situation in order to improve economic self-sufficiency. Financial Coaching Plus includes the development of a personal budget and identifies reliable and trusted savings, credit, and debt programs that promote financial stability. The content and direction of the coaching is customized to respond to the individual financial goals set by the participant. Financial coaching is provided to the client one-on-one in a setting convenient for the client over a time-limited series of sessions and follow-up to increase the opportunity for self-directed behavior skills learning. The Financial Coach will:<br>• 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;<br>• Ensure that individuals understand the availability of various tax credits such as the Earned Income Tax Credit, Child Care Tax Credit, and others;<br>• Refer individuals as needed to benefit counselors;<br>• Provide information to complement information provided through benefits counseling regarding appropriate asset building;<br>• 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;<br>• Provide information about how to protect personal identify and avoid predatory lending schemes;<br>• Provide assistance with filing yearly taxes either through the IRS VITA program or its virtual program that involves self-filing.<br>The Financial Coaching Plus service will include the collection and maintenance of proper documentation of services provided as required by the Department that will track goals, actions, and outcomes of individual participants. The Financial Coaching Plus service may complement information provided on the use of public benefits and/or work incentives through Benefits Counseling or other services. Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.) or other services |

| HCBS Service | Service Definition |
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| IADL/chore | IADL/chore services are delivered to beneficiaries that reside in a private home and are necessary, as specified in the Recovery Plan, to enable the beneficiary to integrate more fully into the community and to ensure the health, welfare, and safety of the beneficiary.<br><br>This service will be provided to meet the beneficiary's needs, as determined by an assessment performed in accordance with department requirements and as outlined in the beneficiary's Recovery Plan.<br><br>IADL services consist of the performance of general household tasks (e.g., meal preparation, cleaning, laundry, and other routine household care) provided by a qualified homemaker when the beneficiary regularly responsible for these activities is absent or unable to manage the home and care for him or herself or others in the home, or when no landlord or provider agency staff is responsible to perform the IADL services.<br><br>Chore services consist of services provided to maintain the home in a clean, sanitary, and safe condition. This service includes heavy household chores, such as:<br>• Washing floors, windows, and walls.<br>• Tacking down loose rugs and tiles.<br>• Moving heavy items of furniture in order to provide safe access and egress.<br>• Removing ice, snow and/or leaves.<br>• Yard maintenance.<br><br>The providers of this service must review and be familiar with the crisis support plan. IADL/chore services may not be billed at the same time as personal care or respite services.<br><br>IADL/chore services are limited to 40 hours per beneficiary per service plan Recovery Plan year when the beneficiary or family member(s) or friend(s) with whom the beneficiary resides is temporarily unable to perform and financially provide for the IADL/chore functions. |
| Individual employment support services (IESS) | IESS are services to beneficiaries needing on-going individualized support to learn a new job or to maintain a job in a competitive or customized integrated work setting that meets job and career goals (including self-employment). Beneficiaries in a competitive employment arrangement receiving IESS are compensated at or above the minimum wage and receive similar wages and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. IESS are necessary, as specified in the Recovery Plan, to support the beneficiary to live and work successfully in home and community-based settings, enable the beneficiary to integrate more fully into the community and ensure the health, welfare, and safety of the beneficiary.<br><br>Supported beneficiary employment may also include support to establish or maintain self-employment, including home-based self-employment. Supported employment services are individualized and may include any combination of the following services: on-going vocational/job-related discovery or assessment not otherwise covered in the annual career planning, on-going person-centered employment planning not otherwise covered in the annual career planning, job placement, job development negotiation with prospective employers, job analysis, job carving, training and systematic instruction, individual supports, benefits support, training, planning, transportation, asset development and career advancement services, implementation of assistive technology, and other workforce support services including services not specifically related to job skill training that enable the waiver beneficiary to be successful in integrating into the job setting. Supported employment includes person-centered, comprehensive employment planning and support services that provide assistance for waiver program beneficiaries to obtain, maintain, or advance in competitive employment or self-employment. This employment planning includes engaging a beneficiary in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state's minimum wage. The outcome of this activity is |

| HCBS Service | Service Definition |
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| | documentation of the beneficiary's stated career objective and a career plan used to guide beneficiary employment support.<br><br>Competitive or customized integrated employment, including self-employment, shall be considered the first option when serving beneficiaries with disabilities who are of working age. IESS adopt a "rapid job search" approach to achieving competitive employment and services planned do not assume that a beneficiary must achieve greater readiness for competitive employment before competitive employment is sought.<br><br>Supported employment may provide work experiences where the beneficiary can develop strengths and skills that contribute to employability in paid employment in integrated community settings. IESS include supervision, monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills and training and education in self-determination. |

| HCBS Service | Service Definition |
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| IESS (cont'd) | Skills development as a part of placement and training may occur as a one-to-one training experience in accordance with department requirements. IESS may be utilized for a beneficiary to gain work related experience considered crucial for job placement (e.g., unpaid internship), if such experience is vital to the person achieve his or her vocational goal. Provide and support the acquisition of skills necessary to enable the beneficiary to obtain competitive, integrated work where the compensation for the beneficiary is at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities, which is considered to be the optimal outcome of IESS.<br><br>In addition to the elements note above, IESS provides two components in accordance with an assessment: intensive IESS and extended follow-along.<br><br>Intensive IESS is an essential component of individual employment support services and may include:<br>• On the job training and skills development.<br>• Assisting the beneficiary with development of natural supports in the workplace.<br>• Helping the beneficiary to attend school and providing academic supports, when that is their preference.<br>• Coordinating with employers or employees, coworkers and customers, as necessary. (Note: Coordinating with employers and other employees is done only if the beneficiary prefers to have her or his mental illness disclosed and gives permission. Supporting the beneficiary's preference in this area is fundamental to recovery.)<br>• Providing work incentives planning prior to or during the process of job placement. Work incentives planning involves helping the beneficiary review her or his options for working (number of hours per week, etc.), given the hourly pay the beneficiary is being offered, or is likely to be offered, the beneficiary's current income needs, and the rules concerning how Social Security Administration benefits, medical benefits, medical subsidies, and other subsidies (housing, food stamps, etc.) change based on income from paid employment. (This includes providing information on Ticket to Work, etc.). Work incentives planning allows beneficiaries to make informed decisions about how many hours per week to work, as well as their preferred timing in moving from part-time to full-time work. Beneficiaries also are given information and assistance about reporting earnings to various sources of entitlements/benefits.<br>• Assisting beneficiaries in making informed decisions about whether to disclose their mental illness condition to employers and co-workers.<br>• Intensive IESS includes assisting the beneficiary in meeting employment expectations, performing business functions, addressing issues as they arise, and also includes travel training, and diversity training to the specific business where the beneficiary is employed. Intensive IESS provides support to assist beneficiaries in stabilizing in an integrated situation (including self-employment) and may include activities on behalf of the beneficiary when the beneficiary is not present to assist in maintaining job placement. Once the beneficiary is stable in the position, extended follow along will ensue.<br><br>Extended follow-along is ongoing support available for an indefinite period as needed by the beneficiary to maintain their paid employment position once they have been stabilized in their position (generally receiving onsite support once per month or less). Extended follow-along support may include reminders of effective workplace practices and reinforcement of skills gained during the period of intensive IESS. |
| Non-medical transportation | Non-medical transportation services are offered, in addition to any medical transportation furnished under the 42 CFR 440.17(a) in the State Plan. Non-medical transportation services are necessary, as specified by the Recovery Plan, to enable beneficiaries to gain access to |

| HCBS Service | Service Definition |
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| | waiver services that enable them to integrate more fully into the community and ensure the health, welfare, and safety of the beneficiary. In order to be approved, non-medical transportation would need to be directly related to a goal on the beneficiary's treatment plan (e.g., to a supported employment job) and not for the general transportation needs of the client (e.g., regular trips to the grocery store). This service will be provided to meet the beneficiary's needs as determined by an assessment performed in accordance with department requirements and as specifically outlined in the beneficiary's Recovery Plan.<br><br>Transportation services consist of:<br><br>• Transportation (mile): This transportation service is delivered by providers, family members, and other qualified, licensed drivers. Transportation (mile) is used to reimburse the owner of the vehicle or other qualified, licensed driver who transports the beneficiary to and from services and resources related to outcomes specified in the beneficiary's Recovery Plan. The unit of service is one mile. Mileage can be paid round trip. A round trip is defined as from the point of first pickup to the service destination and the return distance to the point of origin. When transportation (mile) is provided to more than one beneficiary at a time, the provider will divide the shared miles equitably among the beneficiaries to whom transportation is provided. The provider is required (or it is the legal employer's responsibility under the Vendor Fiscal/Employer Agent model) to track mileage, allocate a portion to each beneficiary, and provide that information to the care manager for inclusion in the beneficiary's Recovery Plan.<br><br>• Public transportation: The utilization of public transportation promotes self-determination and is made available to beneficiaries as a cost-effective means of accessing services and activities. This service provides payment for the beneficiary's use of public transportation.<br><br>The care manager will monitor this service quarterly and will provide ongoing assistance to the beneficiary to identify alternative community-based sources of transportation. |
| Nursing | Nursing services are prescribed by a physician in addition to any services under the State Plan as determined by an assessment in accordance with department requirements. Nursing services are necessary, as specified in the Recovery Plan, to enable the beneficiary to integrate more fully into the community and ensure the health, welfare, and safety of the beneficiary. This service is intended to be utilized in the beneficiary's home.<br><br>Services are provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse licensed to practice in the State. The physician's order to reauthorize must be obtained every ninety (90) days for continuation of service. If changes in the beneficiary's status take place after the physician's order, but prior to the reauthorization of the service, and result in a change in the level of services authorized in the Recovery Plan, the provider is responsible for reporting to the ordering physician and care manager.<br><br>Nursing services must be performed by a registered nurse or licensed practical nurse as defined by the State Nurse Practice Act. Skilled nursing is typically provided on a one to one basis and can be continuous, intermittent, or short-term, based on the beneficiary's assessed need.<br><br>• Short-term or intermittent nursing: Nursing that is provided on a short-term or intermittent basis, not expected to exceed 75 units of service in a Recovery Plan year and are over and above services available to the beneficiary through the State Plan. |
| Nursing (cont) | • Long-term or continuous nursing: Long-term or continuous nursing is needed to meet ongoing assessed needs that are likely to require services in excess of 75 units per Recovery Plan year, are provided on a regular basis and are over and above services available to the beneficiary through the State Plan. Services must be delivered in a manner that supports the beneficiary's communication needs including, but not limited to age appropriate communication, translation services for beneficiary's that are of limited-English proficiency or who have other communication needs requiring translation, |

| HCBS Service | Service Definition |
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| | assistance with the provider's understanding and use of communication devices used by the beneficiary.<br><br>The nursing service provider must maintain documentation in accordance with department requirements. The documentation must be available to the care manager for monitoring at all times on an ongoing basis. The care manager will monitor on a quarterly basis to see if the objectives and outcomes are being met. |
| Peer supports (PS) | PS services are beneficiary-centered services with a rehabilitation and recovery focus designed to promote skills for coping with and managing psychiatric symptoms, while facilitating the utilization of natural resources and the enhancement of recovery-oriented attitudes such as, hope and self-efficacy, and community living skills. Activities included must be intended to achieve the identified goals or objectives as set forth in the beneficiary's individualized care plan, which delineates specific goals that are flexibly tailored to the beneficiary and attempt to utilize community and natural supports. The structured, scheduled activities provided by this service emphasize the opportunity for beneficiaries to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery.<br><br>A certified peer/recovery coach would be a beneficiary who has self-identified as a beneficiary or survivor of mental health or SUD services and meets the qualifications set by the State including specialized training, to be considered in accordance with State standards, certification, and registration. The training provided/contracted by DSAMH shall be focused on the principles and concepts of PS and how it differs from clinical support. It will also provide practical tools for promoting wellness and recovery, knowledge about beneficiary rights and advocacy, as well as approaches to care that incorporate creativity. To qualify for peer certification training a peer/recovery coach must self-identify as a person with a lived experience of mental illness and/or substance abuse, be at least 21 years of age, have at minimum a high school education or General Education Development certificate, (preferably with some college background) and be currently employed as a peer supporter in Delaware. It is required that peers/recovery coaches must complete Delaware State-approved standardized peer specialist training that includes academic information as well as practical knowledge and creative activities.<br><br>A peer/recovery coach uses lived experience with a mental illness, SUD, or another co-occurring disorder such as PH, developmental disability, etc. or assist in supporting beneficiaries in their recovery path. |

| HCBS Service | Service Definition |
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| PS (cont'd) | This service may include the following components:<br>• Helps beneficiaries aspire to and attain roles which emphasize their strengths by:<br>— Sharing parts of their own personal recovery story and first hand experiences. Providing mutual support, hope, reassurance, and advocacy.<br>— Provides PS to beneficiaries regarding understanding their symptoms of mental illness and effects of trauma and trauma history, developing positive coping skills.<br>— Engaging beneficiaries through outreach and support.<br>— Assists beneficiaries to advocate for self and others.<br>— Promotes recovery through modeling by:<br>− Sharing one's own personal recovery story.<br>− Display of self-confidence and self-determination.<br>− Use of natural supports including connections to friends and family, peer mutual help groups, and other supports in the community.<br>− Display of personal achievements of personal recovery goals.<br>− Helps the beneficiary to develop a network for information and support from others who have been through similar experiences.<br>− Assists the beneficiary with gaining and regaining the ability to make independent choices and to take a proactive role in treatment, including discussing questions or concerns about medications, diagnoses or treatment approaches with their treating clinician.<br>− Assists the beneficiary with identifying and effectively responding to or avoiding identified precursors or triggers that result in functional impairments.<br>− Assists the beneficiary to complete peer-related elements of a comprehensive assessment.<br>− Prepares the beneficiary to attend their recovery plan meetings and is present to assist them express their goals and needs.<br>− Assists beneficiary to accomplish their life goals of living in a chosen community, including working in a job and engaging in activities, including leisure activities, to support community integration, having a natural support system in place, and having a number of hobbies or activities that are creative and integrated community leisure activities. |

| HCBS Service | Service Definition |
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| PS (cont'd) | − Works with the beneficiary and staff in developing and implementing person-directed beneficiary recovery plans, using both their own expertise, based on their lived experience, as well as evidence-based tools, such as Wellness Recovery Action Planning.<br>− Assists in helping the beneficiary to work on their beneficiary wellness plan for physical and emotional wellness. These services might include physical exercise, dietary assistance, recognition of medical/healthcare needs, introduction to alternative healing techniques such as meditation or massage, etc. PS specialists are primarily expected to engage beneficiaries and provide personalized individualized support toward recovery. However, PS specialists may assist with IADLs, when they are assessed to be important aspects of the recovery process for a person to whom the PS specialist is providing services, consistent with the broader PS role.<br>− Facilitates peer recovery support groups. Accompanies beneficiaries to appointments which connect them to community resources and services. Under this service, the peer staff should not provide transportation. If the peer provides non-medical transportation, the peer should be enrolled as a transportation provider and separately charge for the non-medical transportation service instead of peer support. Peers should not be routinely used to provide client transportation.<br>− Acts as an advocate for beneficiaries to secure needed services, financial entitlements, and effectively raise complaints and suggestions about unmet needs, and helps beneficiaries develop self-advocacy skills.<br>− Locates peer-run programs and support groups for interested beneficiaries.<br>− Participates in the ongoing engagement of beneficiaries.<br>A peer specialist/recovery coach should ensure that the following occur:<br>• Maintains compliance with all applicable practice standards and guidelines.<br>• Maintains beneficiary confidentiality and adherence to Health Insurance Portability & Accountability Act requirement at all times.<br>• Completes all required documentation in a timely manner consistent with agency guidelines.<br>• Maintains agency required productivity standards.<br>Peer specialists/recovery coaches may function within a team or work with the beneficiary on a beneficiary basis. Peer specialists/recovery coaches may serve on ACT and ICM teams. If the PS functions within a team, then the peer/recovery coach:<br>• Provides training and education to the beneficiary and other members of the beneficiary's team on:<br>— Recovery-oriented care and processes.<br>— Local and national PS resources and advocacy organizations.<br>— Psychiatric advance directives: advocacy, information, and referral.<br>— Recovery planning, illness self-management, and wellness tools.<br>— Trauma informed care.<br>— Use of expressive therapies.<br>— Is not used primarily to complete tasks that clinicians or other specialists on the team do not want to complete, such as transport beneficiaries, complete paper work, and so on. |

| HCBS Service | Service Definition |
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| PS (cont'd) | PS is a face-to-face intervention with the beneficiary present. Services may be provided individually or in a group setting. The majority of PS contacts must occur in community locations where the person lives, works, attends school, and/or socializes. |
| Personal care | Personal care includes care with ADLs (e.g., bathing, dressing, personal hygiene, transferring, toileting, skin care, eating, and assisting with mobility). When specified in the Recovery Plan, this service includes care with IADLs (e.g., light housekeeping, chores, shopping, meal preparation). Care with IADLs must be essential to the health and welfare of the beneficiary based on the assessment of the care manager and identified within the Recovery Plan as a goal that was identified by the beneficiary. Input should also be obtained from the beneficiaries' family or other natural supports, when appropriate and desired by the beneficiary.<br><br>Personal care services primarily provide hands-on care to beneficiaries that reside in a private home and that are necessary, as specified in the Recovery Plan, to enable the beneficiary to integrate more fully into the community and ensure the health, welfare, and safety of the beneficiary.<br><br>This service will be provided to meet the beneficiary's needs, as determined by an assessment, in accordance with department requirements and as outlined in the beneficiary's Recovery Plan.<br><br>The provider and beneficiary will be encouraged to hire staff to deliver personal care services separate from staff who provide habilitation services that involved the development of ADL and IADL skills, if there is more than one staff member on site at the residence during normal hours who can provide personal care services. This will ensure that the clinical boundary issues that would otherwise complicate habilitation services (if the same staff were also delivering personal care services) will be mitigated.<br><br>Personal care services are aimed at assisting the beneficiary with completing ADLs that would be performed independently if they had no disability. These services include:<br>• Care to assist with daily living activities (e.g., eating, bathing, dressing, personal hygiene), cueing to prompt the beneficiary to perform a task and providing supervision to assist a beneficiary who cannot be safely left alone.<br>• Health maintenance, such as bowel and bladder routines, ostomy care, catheter, wound care, and range of motion, as indicated in the beneficiary's Recovery Plan and permitted under applicable State requirements.<br>• Routine support services, such as meal planning, keeping of medical appointments, and other health regimens needed to support the beneficiary.<br>• Care and implementation of prescribed therapies.<br>• Overnight personal care services to provide intermittent or ongoing awake, overnight care to a beneficiary in their home for up to eight hours. Overnight personal care services require awake staff.<br><br>Personal care may include care with the following activities when incidental to personal care and necessary to complete ADLs:<br>• Activities that are incidental to the delivery of the personal care to assure the health, welfare, and safety of the beneficiary such as changing linens, doing the dishes associated with the preparation of a meal, laundering of towels from bathing may be provided and must not comprise the majority of the service.<br>• Services to accompany the beneficiary into the community for purposes related to personal care, such as shopping in a grocery store, picking up medications, and providing care with any of the activities noted above to enable the completion of those tasks. |

| HCBS Service | Service Definition |
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| Personal care (cont'd) | Services must be delivered in a manner that support the beneficiary's communication needs including, but not limited to age appropriate communication, translation services for beneficiaries that are of limited-English proficiency or who have other communication needs requiring translation, care with the provider's understanding, and use of communication devices used by the beneficiary.<br><br>The personal care service provider must maintain documentation in accordance with department requirements. The documentation must be available to the care manager for monitoring at all times on an ongoing basis. The care manager will monitor on a quarterly basis to see if the objectives and outcomes are being met. |
| Psychosocial rehabilitation (PSR) | PSR services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid eligible adults with significant functional impairments meeting the need levels in the PROMISE program resulting from an identified mental health or substance abuse disorder diagnosis. The medical necessity for these rehabilitative services must be determined by a LBHP or physician who is acting within the scope of his/her professional license and applicable state law and furnished by or under the direction of a licensed practitioner, to promote the maximum reduction of symptoms and/or restoration of a beneficiary to his/her best age-appropriate functional level conducting an assessment consistent with state law, regulation, and policy. A unit of service is defined according to the HCPCS approved code set unless otherwise specified.<br><br>**Definitions**<br><br>PSR services are designed to assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness and/or SUD. Activities included must be intended to achieve the identified goals or objectives as set forth in the beneficiary's Recovery Plan. The intent of PSR is to restore the fullest possible integration of the beneficiary as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention. PSR is a face-to-face intervention with the beneficiary present. Services may be provided individually or in a group setting and should utilize (with documentation) evidence-based rehabilitation interventions. Group PSR sessions may not include more than eight beneficiaries in attendance. This service may include the following components:<br><br>• Restoration, rehabilitation, and support with the development of social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, develop coping strategies, and effective functioning in the beneficiary's social environment including home, work, and school.<br><br>• Restoration, rehabilitation, and support with the development of daily living skills to improve self management of the negative effects of psychiatric or emotional symptoms that interfere with a beneficiary's daily living. Supporting the beneficiary with development and implementation of daily living skills and daily routines critical to remaining in home, school, work, and community.<br><br>• Assisting the beneficiary with implementing learned skills so the beneficiary can remain in a natural community location.<br><br>• Assisting the beneficiary with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.<br><br>• Ongoing in-vivo assessment of the beneficiary's functional skill and impairment levels that is used to select PSR interventions and periodically assess their effectiveness. Workers who provide PSR services should periodically report to a supervising licensed practitioner on the beneficiaries' progress toward the recovery and re-acquisition of skills. |

| HCBS Service | Service Definition |
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| Respite | Respite care includes services provided to beneficiaries unable to care for themselves furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the beneficiary. Respite may be provided in an emergency to prevent hospitalization. Respite provides planned or emergency short-term relief to a beneficiary's unpaid caregiver or principle caregiver who is unavailable to provide support. This service will be provided to meet the beneficiary's needs as determined by an assessment performed in accordance with department requirements and as outlined in the beneficiary's Recovery Plan. Beneficiaries are encouraged to receive Respite in the most integrated and cost-effective settings appropriate to meet their respite needs.<br><br>Respite services may include the following activities:<br>• Assistance with the beneficiary's social interaction, use of natural supports and typical community services available to all people and participation in volunteer activities.<br>• Activities to improve the beneficiary's capacity to perform or assist with activities of daily living and instrumental activities of daily living.<br>• Onsite modeling of behavior, behavior support, intensive behavior episode intervention, training, cueing, and/or supervision.<br><br>**Respite 15-minute Unit**<br><br>Respite (15-minute unit) may be provided in the beneficiary's home or out of the beneficiary's home (not in a facility) in units of 15-minutes, for up to 12 hours a day. It is intended to provide short-term respite.<br><br>**Respite Per diem**<br><br>Respite (per diem) may be provided in a facility on a per diem basis. It is intended to provide short-term respite.<br><br>Services must be delivered in a manner that supports the beneficiary's communication needs including, but not limited to, age appropriate communication, translation services for beneficiaries that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding, and use of communication devices used by the beneficiary.<br><br>If the beneficiary is to receive respite on an ongoing basis, the care manager will monitor on a quarterly basis, as applicable, to see if the objectives and outcomes are being met. |

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| Short-term small group supported employment | Short-term small group supported employment services provide support to beneficiaries to gain skills to enable transition to integrated, competitive employment. This service is provided, instead of IESS only when the beneficiary specifically chooses this service over IESS, based on a desire to work in a group context, or to earn income more quickly than might be possible with an individualized rapid job search through IESS. Short-term small group supported employment supports are services and training activities provided in regular business, industry, and community settings for groups of two (2) to four (4) workers with disabilities. Examples include mobile crews and other employment work groups. Small group employment support must be provided in a manner that promotes integration into the workplace and interaction between beneficiaries and people without disabilities in those workplaces. The outcome of this service is sustained paid employment and work experience leading to further career development and beneficiary integrated community-based employment. Within this service, the beneficiary is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.<br><br>Short-term small group supported employment supports may be a combination of the following services: on the job supports, initial and ongoing employment planning and advancement, employment assessment not otherwise covered in the annual career planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefits supports training and planning transportation. If the beneficiary has received a career assessment that has determined that the beneficiary is in need of acquiring particular skills in order to enhance their employability, those identified skill development areas must be addressed within the beneficiary's Recovery Plan and by the short-term small group supported employment support. Beneficiaries receiving this service must have an employment outcome goal included in their Recovery Plan.<br><br>On the job support includes: onsite job training, assisting the beneficiary to develop natural supports in the workplace, coordinating with employers and coworkers, as necessary, to assist the beneficiary in meeting employment expectations and addressing issues as they arise. Other workplace support services may include services not specifically related to job skill training that enable the waiver beneficiary to be successful in integrating in to the job setting.<br><br>Short-term small group supported employment supports includes person-centered, comprehensive employment planning and support service that provides assistance for waiver program beneficiaries to obtain, maintain, or advance in competitive employment or self-employment. This employment planning includes engaging a beneficiary in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state's minimum wage. The outcome of this activity is documentation of the beneficiary's stated career objective and a career plan used to guide beneficiary employment support. |

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| Short-term small group supported employment (cont'd) | Short-term small group supported employment supports emphasize the importance of rapid job search for a competitive job and provide work experiences where the beneficiary can develop strengths and skills that contribute to employability in individualized paid employment in integrated community settings. Short-term small group supported employment supports include the provision of scheduled activities outside of a beneficiary's home that support acquisition, retention, or improvement in self-care, sensory-motor development, socialization, daily living skills, communication, community living, and social skills. Short-term small group supported employment supports include supervision, monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills and training and education in self-determination. Skills development as a part of placement and training may occur as a one-to-one training experience in accordance with department requirements. Short-term small group supported employment supports will be utilized for a beneficiary to gain work related experience considered crucial for job placement (e.g., unpaid internship). Provide and support the acquisition of skills necessary to enable the beneficiary to obtain competitive, integrated work where the compensation for the beneficiary is at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities, which is considered to be the optimal outcome of short-term small group supported employment supports.<br><br>Services must be delivered in a manner that supports the beneficiary's communication needs including, but not limited to age appropriate communication, translation services for beneficiaries that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding, and use of communication devices used by the beneficiary.<br><br>This service may be delivered in Delaware and in states contiguous to Delaware.<br><br>The short-term small group supported employment supports service provider must maintain documentation in accordance with department requirements. The documentation must be available to the care manager for monitoring at all times on an on-going basis. The care manager will monitor on a quarterly basis to see if the objectives and outcomes are being met.<br><br>Competitive and integrated employment, including self-employment, shall be considered the first option when serving persons with disabilities who are of working age. |

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

**Delaware**
1115 Waiver Amendment
8/29/2014

State of Delaware website where PROMISE 1115 WAIVER Amendment is published both on Division of Substance Abuse and Mental Health and Division of Medicaid & Medical Assistance webpages.

http://www.dhss.delaware.gov/dsamh/


http://dhss.delaware.gov/dhss/dmma/