DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

November 21, 2024

Andrew Wilson
Director
Division of Medicaid and Medical Assistance
Department of Health and Social Services
1901 N. Dupont Highway
New Castle, DE 19720

Dear Director Wilson:

The Centers for Medicare & Medicaid Services (CMS) is issuing technical corrections to the Delaware section 1115 Medicaid demonstration, entitled "Delaware Diamond State Health Plan" (Project Number 11-W-00036/3) Extension, which was approved on May 17, 2024, under the authority of section 1115(a) of the Social Security Act (the Act). CMS has issued the following technical corrections to the special terms and conditions (STCs):

1. Updated the footers to change the Approval Date from January 1, 2024 to July 1, 2024.

2. Updated pages one, five and seven, changed the Project Number from 11-W-00036/4 to 11-W-00036/3.

3. Updated page twenty-six, STC #23 (b) to read, "ii. Day services authorized by the Division of Developmental Disabilities Services and iii. Medically necessary behavioral health services for children in excess of MCO plan benefit coverage, which is 30 visits for children;"

4. Updated page twenty-six, STC #23 (b) to change "iii. Medically necessary behavioral health services for adults under the PROMISE program to iv. Medically necessary behavioral health services for adults under the PROMISE program;"

5. Updated page twenty-seven, STC #23 (b) to change "iv. Prescribed pediatric extended care; to v. Prescribed pediatric extended care;"

6. Updated page twenty-seven, STC #23 (b) to change "v. Targeted case management (TCM). to vi. Targeted case management (TCM), except as necessary to fulfill the requirements under section 1902(a)(84)(D) of the Act."

7. Updated page thirty, STC #32 (a), to read, “Beginning no earlier than July 1, 2024, DMMA will implement a new contingency management benefit for qualifying beneficiaries with a stimulant use disorder and/or opioid use disorder (OUD) in eligible provider settings.”

8. Updated page thirty-five, STC# 38, sentence two to read, “To the extent feasible, the state will conduct the evaluation to support assessment stratified by stimulant use disorder, opioid use disorder, and other types of SUD.”

9. Updated page forty-seven, STC# 56 (b) to correct formatting.

10. Updated page sixty-seven, Table E Master MEG Chart, MEG column to DSHP TEFRA-Like to DSHP TEFRA Like-Children.

11. Updated page sixty-eight, Table E Master MEG Chart to include the Postpartum Nutrition Support and Contingency Management MEGs.

12. Updated page seventy-five, Table F: MEG Detail for Expenditure and Member Month Reporting, MEG (Waiver name) column to change DSHP TEFFRA-Like to DSHP TEFRA- Like Children.

13. Updated page seventy-five, Table F: MEG Detail for Expenditure and Member Month Reporting, Report Member Months (Y/N) column, DSHP TEFRA- Like Children row to change Y Report months of Medicaid eligibility for DSHP TEFRA-Like, as defined in Table A. Exclude SUD IMD months to Y Report months of Medicaid eligibility for DSHP TEFRA-Like, as defined in Table A. Exclude SUD IMD months. TEFRA months are calculated by taking 5% of total SSI Children (and reducing the SSI Children months by that amount).

14. Updated page seventy-six, Table F: MEG Detail for Expenditure and Member Month Reporting to include the Postpartum Nutrition Support Initiatives.

15. Updated page seventy-seven, Table F: MEG Detail for Expenditure and Member Month Reporting to include the Contingency Management.

16. Updated page eighty-three, Table H: Main Budget Neutrality Test to include the Contingency Management and Postpartum Nutrition Initiative MEGs.

17. Updated page eighty-five, STC# 105, to change DSHP TEFRA-Like to DSHP TEFRA-Like Children.

18. Updated page eighty-six, Table K: Hypothetical Budget Neutrality Test 3 to change DSHP TEFRA-Like to DSHP TEFRA-Like Children.

19. Updated page eighty-seven, to delete the Maine Budget Neutrality Test 5 STC and Table M: Main Budget Neutrality Test 5.

20. Updated pages eighty-seven and eighty-eight to change Table N: Savings Phase Down and Table O: Budget Neutrality Test Mid-Course Correction Calculation to Table M: Savings Phase Down and Table N: Budget Neutrality Test Mid-Course Correction Calculation.

21. Updated pages one hundred twenty-six and one hundred twenty-seven, added the Tier two, Tier three and Tier four service definitions for the PROMISE program.

To reflect the agreed terms between the state and CMS, CMS has incorporated the technical changes into the latest version of the STCs. Please find enclosed the updated STCs.

Your project officer for this demonstration is Ms. Wanda Boone-Massey. She is available to answer any question concerning your section 1115 demonstration at Wanda.Boone-Massey@cms.hhs.gov.

Sincerely,

For
Andrea J. Casart
Director
Division of Medicaid Expansion Demonstrations

Enclosure

cc: Nicole Guess, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00036/3**

TITLE: **Delaware Diamond State Health Plan**

AWARDEE: **Delaware Department of Health & Social Services**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Delaware for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration extension, through December 31, 2028, be regarded as expenditures under the state's title XIX plan. All previously approved expenditure authorities for this demonstration are superseded by those set forth below for the state's expenditures relating to dates of service during this demonstration extension.

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

1. **217-Like Elderly and Disabled Home and Community Based Services (HCBS) Group**.[1] Expenditures for medical assistance for individuals who are disabled, over age 18,meet the Nursing Facility (NF) level of care (LOC) criteria and who would otherwise be Medicaid-eligible if the state had elected the group described in section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR 435.217 in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if enrolled and receiving services under a 1915(c) HCBS waiver program.

2. **217-Like HIV/AIDS HCBS Group**. Expenditures for medical assistance for individuals over age 1, who have a diagnosis of AIDS or HIV, who meet the hospital LOC criteria, and who would otherwise be Medicaid-eligible if the state had elected the eligibility group described in section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR 435.217 in conjunction with

[1] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-C/subject-group-ECFR92b90bbfe1e24d9/section-435.217

section 1902(a)(10)(A)(ii)(V) of the Act, and they were enrolled and receiving services under a 1915(c) HCBS waiver program.

3. **"At-risk" for Nursing Facility Group**. Expenditures for medical assistance for individuals who are disabled, over age 18,with incomes at or below 250 percent of the Supplemental Security Income (SSI) Federal Benefit Rate and who do not meet the nursing facility level of care (NF LOC) but are "at-risk" for institutionalization.

4. **TEFRA-Like Group.** [2] Expenditures for medical assistance for children under age 18 who are disabled, with incomes at or below 250 percent of the SSI who do not meet the NF LOC but are "at-risk" of institutionalization absent the provision of DSHP services. The state will use financial institutional eligibility rules for individuals who would not be eligible in the community because of community deeming rules (in the same manner that would be used if the group were eligible under the state plan).

5. **Continuing Receipt of Nursing Facility Care.** Expenditures for medical assistance for nursing facility residents, who do not currently meet the NF LOC criteria, but continue to meet the NF level of care criteria in place at the time of admission/enrollment.

6. **Continuing Receipt of Home and Community-Based Services.** Expenditures for medical assistance for individuals receiving HCBS for the disabled and elderly, who do not meet the NF LOC criteria, but continue to meet the LOC criteria in place at the time of enrollment, including HCBS furnished under a terminated 1915(c) waiver.

7. **Continuing Receipt of Medicaid State Plan Services.** Expenditures for medical assistance for disabled children with incomes at or below 250 percent of the SSI, who do not meet the NF or hospital LOC criteria but continue to meet the LOC criteria in place at the time of their enrollment.

8. **PROMISE Services.** Expenditures for behavioral health services beyond the services described in the approved state plan for otherwise eligible

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[2] Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat.375 (1982). chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.govinfo.gov/content/pkg/STATUTE-96/pdf/STATUTE-96-Pg324.pdf

individuals enrolled in the Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) program.

9. **HCBS for Medicaid State Plan Eligibles.** Expenditures to provide HCBS not included in the Medicaid State Plan to individuals who are eligible for Medicaid as described in the STCs.

10. **Residential and Inpatient Treatment for Individuals with a Substance Use Disorder (SUD).** Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an Institution for Mental Diseases (IMD).

11. **Respite Benefit for Caregivers of Children and Young Adults.** Expenditures to provide coverage of a pediatric respite benefit for individuals up to age 21 who are not receiving respite through PROMISE or the Lifespan 1915(c) waiver.

12. **Self-directed Personal Care/Attendant Care for Children.** Expenditures to provide self-directed personal care/attendant care for children receiving personal care services which is provided under the state plan home health benefit.

13. **Evidence-based Home Visiting Models**. Expenditures to provide two models of evidenced- based home visiting for pregnant women and children through the Nurse Family Partnership (children up to the age of two) and Healthy Families Delaware (up through the child's third birthday).

14. **Nursing Facility Transition Services.** Expenditures to provide coverage of short-term nursing facility transition services to support a DSHP Plus member's transition from a nursing facility to an HCBS setting.

15. **Postpartum Nutrition Supports Initiative:** Expenditures to provide the equivalent of up to two meals a day (home-delivered meals and/or food boxes) that do not constitute a full nutritional regimen, up to eighty diapers per week, and up to one pack of baby wipes per week delivered to postpartum beneficiaries, for the first twelve weeks of the postpartum period. The Postpartum Nutrition Supports Initiative services may not supplant any other funding for nutrition supports available to the beneficiary through local, state, or federal programs.

16. **Expenditures Related to Contingency Management.** Expenditures for contingency management services provided to qualifying beneficiaries from a provider that has been approved by Division of Medicaid and Medical Assistance (DMMA) to deliver the Contingency Management benefit.

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBER: **11-W-00036/3**

TITLE: **Delaware Diamond State Health Plan**

AWARDEE: **Delaware Department of Health & Social Services**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the demonstration project through December 31, 2028, unless otherwise specified. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs). All previously approved waivers for this demonstration are superseded by those set forth below for the state's expenditures relating to dates of service during this demonstration extension.

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

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

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

To enable the state to provide contingency management services through approved providers to eligible individuals with stimulant use disorders and/or opioid use disorders, that are not otherwise available to other beneficiaries in the same eligibility group.

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

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

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

To the extent necessary to enable Delaware to restrict freedom-of-choice of provider through the use of mandatory enrollment into managed care plans for DSHP and DSHP- Plus participants. To the extent necessary to enable the state to use selective contracted fee-for-service (FFS) providers, including for Home and Community Based Services (HCBS) and a transportation broker for non-medical transportation. No waiver of freedom of choice is authorized for family planning providers. Additionally, to enable the state to restrict freedom of choice of provider for the Postpartum Nutrition Supports Initiative and contingency management services.

4. Retroactive Eligibility **Section 1902(a)(34)**

To the extent necessary to enable Delaware to not extend eligibility to DSHP and DSHP- Plus participants prior to the date that an application for assistance is made, with the exception of institutionalized individuals in nursing facilities and qualified disabled working individuals (QDWIs), as outlined in Table A of the STCs. The waiver of retroactive eligibility does not apply to pregnant women (including during the 12 months postpartum period beginning on the last day of the pregnancy), infants under age 1, or individuals under age 19. This waiver will sunset on January 1, 2025.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STCs)

NUMBER: **11-W-00036/3**

TITLE: **Delaware Diamond State Health Plan 1115(a) Demonstration**

AWARDEE: **Delaware Department of Health & Social Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Delaware's Diamond State Health Plan (DSHP) section 1115(a) Medicaid demonstration (hereinafter "demonstration") to enable the Delaware Department of Health & Social Services (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Act, and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted. The STCs are effective as of the date of the approval letter, unless otherwise specified.

These STCs related to the programs for those state plan and waiver populations affected by the demonstration are effective through December 31, 2028.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility
V. DSHP Benefits
VI. DSHP Plus Benefits
VII. Substance Use Disorder (SUD) Program
VIII. PROMISE Benefits
IX. Cost Sharing
X. Enrollment
XI. Delivery Systems
XII. HCBS Service Delivery and Reporting Requirements

II. PROGRAM DESCRIPTION AND OBJECTIVES

Delaware's Diamond State Health Plan (DSHP) 1115 Demonstration was initially approved in 1995 and implemented beginning on January 1, 1996. The original goal of the demonstration was to improve the health status of low-income Delawareans by expanding access to healthcare to more individuals throughout the State; creating and maintaining a managed care delivery system with an emphasis on primary care; and controlling the growth of healthcare expenditures for the Medicaid population. The DSHP 1115 Demonstration was designed to mandatorily enroll eligible Medicaid recipients into managed care organizations (MCOs) and create cost efficiencies in the Medicaid program that could be used to expand coverage. Delaware achieved its objective of implementation of mandatory managed care focused on primary care in 1996 and invested the resulting waiver savings in Delaware's Medicaid eligibility coverage expansion to uninsured adults up to 100% of the federal poverty level (FPL). Long before Medicaid expansion under the Affordable Care Act, Delaware was a pioneer in coverage expansion for individuals who would otherwise not be eligible for Medicaid. Delaware built upon this success with the eventual expansion of coverage for family planning services, leading up to participating in Medicaid expansion under the Affordable Care Act in 2014.

The demonstration was previously renewed on June 29, 2000, December 12, 2003, December 21, 2006, January 31, 2011, and September 30, 2013.

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

In 2013, the demonstration was renewed and amended to provide authority to extend the low-income adult demonstration population to individuals with incomes up to 100 percent of the FPL until December 31, 2013. After that date, the demonstration population was not necessary because it was included under the approved state plan as the new adult eligibility group authorized under the Affordable Care Act. The new adult group, for individuals with incomes up to 133 percent of the FPL, receive medical assistance through enrollment in MCOs pursuant to this demonstration. In addition, Delaware's authority for the family planning expansion program under this demonstration expired December 31, 2013, when individuals became eligible for Medicaid expansion or Marketplace coverage options.

The demonstration was amended in 2014 to authorize coverage for enhanced behavioral health services and supports for targeted Medicaid beneficiaries through a voluntary program called Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) starting in 2015. PROMISE enrollees include Medicaid beneficiaries who have a severe and persistent mental illness (SPMI) and/or a substance use disorder (SUD) and require HCBS to live and work in integrated settings.

Technical changes were incorporated into the demonstration in October 2017 and an amendment was approved in December 2017 to add coverage for out-of-state former foster care youth.

In July 2019, Delaware was approved for a five-year demonstration extension and an amendment

to provide the state with authority to provide high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD).

On April 25, 2023, the state was approved for an amendment to provide continued eligibility for CHIP enrollees who turn 19 (and therefore, lost eligibility for CHIP due to age) and who are otherwise ineligible for Medicaid due to income above 133 percent of the federal poverty level (FPL) between March 1, 2020, and ending the earlier of the date when all redeterminations for Medicaid and CHIP beneficiaries are conducted during the unwinding period or May 31, 2024.

On June 28, 2023, Delaware was approved for an amendment to add five new benefits under the DSHP section 1115 demonstration. Through the amendment the state will provide: (1) coverage of two models of evidenced-based home visiting for pregnant women and children; (2) ongoing coverage for a second home-delivered meal for members receiving home- and community-based services (HCBS) in DSHP Plus; (3) coverage of a pediatric respite benefit; (4) coverage of a self-directed option for parents on behalf of children receiving state plan personal care services; and (5) coverage of Delaware's Nursing Home Transition Program (formerly Money Follows the Person Demonstration) under the DSHP 1115 demonstration.

On December 30, 2022, Delaware submitted a request to extend the Delaware Diamond State Health Plan for five years. With the approval of the extension, the waiver of retroactive eligibility will sunset effective January 1, 2025, which will expand access by providing three-months of retroactive eligibility to all demonstration enrollees. The state also requested authority to provide three additional benefits including:

1. *Piloting Medicaid coverage of Delaware's Postpartum Nutrition Supports Initiative for postpartum beneficiaries.* Coverage of up to two meals a day (home-delivered meals and/or food boxes) that do not constitute a full nutritional regimen, up to eighty diapers per week, and up to one pack of baby wipes per week delivered to postpartum beneficiaries, for the first twelve weeks of the postpartum period, reaching low-income postpartum members with disproportionately high rates of food insecurity and inequitable adverse maternal and birth outcomes.

2. *Contingency Management Services for certain beneficiaries with a stimulant use disorder and/or opioid use disorder*. Coverage of contingency management services for Medicaid members who are: (1) age 18 and over with a stimulant use disorder diagnosis and/or (2) age 18 and over, who are pregnant or up to 12 months postpartum, with an opioid use disorder diagnosis; and (3) be assessed and determined to have a substance use disorder for which the contingency management benefit is medically necessary and appropriate based on the fidelity of

treatment to the evidence-based intervention, have a completed American Society of Addiction Medicine (ASAM) criteria assessment or other assessment, the results of which indicate that outpatient treatment is medically appropriate for the individual's condition and that they are able to be treated safely in an outpatient setting.

3. *Transitioning children's dental services under the DSHP section 1115 demonstration's managed care delivery model.* Coverage of children's dental services in the DSHP 1115 demonstration managed care delivery system from the fee-for-service delivery system.

Delaware's goals in operating the demonstration are to improve the health status of low-income Delawareans by:

- Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to HCBS;
- Rebalancing Delaware's LTC system in favor of HCBS;
- Promoting early intervention for individuals with, or at-risk, for having, LTC needs;
- Increasing coordination of care and supports;
- Expanding consumer choices;
- Improving the quality of health services, including LTC services, delivered to all Delawareans;
- Creating a payment structure that provides incentives for resources to shift from institutions to community based LTSS services where appropriate;
- Expanding coverage to additional low-income Delawareans;
- Improving overall health status and quality of life of individuals enrolled in PROMISE;
- Increasing and strengthening overall coverage of former foster care youth to improve health outcomes for this population;
- Increase enrollee access and utilization of appropriate SUD treatment services and decrease use of medically inappropriate and avoidable high-cost emergency and hospital services;
- Increasing access to dental services for adults and children, including follow-up care and care for adults with diabetes, and decrease use of emergency department visits for non-traumatic conditions; and
- Improving maternal and infant health outcomes, and health disparities.

The DSHP demonstration includes five distinct components: 1) The DSHP Medicaid managed care program provides Medicaid state plan benefits through a comprehensive managed care delivery system to most recipients eligible under the state plan; 2) The DSHP Plus program provides long-term care services and supports (LTSS) to certain individuals under the State Plan,

and to certain demonstration populations. Further details on these programs are provided in Table A, Sections V through X of the STCs; 3) The PROMISE program provides enhanced behavioral health services fee-for-service (FFS) to Medicaid beneficiaries with a higher level of behavioral health needs and functional limitations who need HCBS to live and work in integrated settings; 4) Coverage for former foster care youth under age 26 who were in foster care under the responsibility of another state or tribe when they "aged out" of foster care at age 18 (or such higher age as elected by the state), were enrolled in Medicaid at that time, and are now residents in Delaware applying for Medicaid; and (5) Coverage for high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as IMDs.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Laws.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Affordable Care Act (Section 1557).

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP, expressed in law, regulation, and policy statement, not expressly waived, or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 calendar days, in writing, in advance of the expected approval date of the amended STCs, to allow the state time to provide comments and establish a reasonable timeframe for implementation of the change. Changes will be considered effective upon issuance of the approval letter by CMS, subject to agreement on an implementation timeframe. The state must accept the changes in writing.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law, regulation, or policy require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under federal law, whichever is sooner.

5. **State Plan Amendments.** The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances, the Medicaid and CHIP state plan governs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below, except as provided in STC 3.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit reports required in the approved STCs and other deliverables in a timely fashion according to the

deadlines specified herein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;
b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
d. An up-to-date CHIP allotment worksheet, if necessary;
e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring, and measurement of the provisions.

8. **Extension of the Demonstration.** States that intend to request a demonstration extension under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than twelve (12) months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets federal requirements at 42 CFR § 431.412(c) or a phase-out plan consistent with the requirements of STC 9.

9. **Demonstration Phase Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:

a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In

addition, the state must conduct tribal consultation in accordance with STC 12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its transition and phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid or CHIP eligibility under a different eligibility category prior to termination as discussed on October 1, 2010, State Health Official Letter #10-008 and as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

e. Exemption from Public Notice Procedures 42 CFR 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the

demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of dis-enrolling beneficiaries.

10. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

11. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

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

    The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

13. **Federal Financial Participation (FFP).** No federal matching for state expenditures under this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

15. **Common Rule Exemption.** The state shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program -including procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(d)(5).

IV. ELIGIBILITY

16. **State Plan Eligibility Groups Affected by the Demonstration.** Mandatory and optional state plan groups described below derive their eligibility through the Medicaid State Plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State Plan, except as expressly waived in this demonstration and as described in these STCs. These state plan eligible beneficiaries are included in the demonstration for use of the managed care network and access to additional benefits not described in the state plan.

Table A. Overview of Eligibility for DSHP and DSHP Plus

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

State Plan Mandatory Medicaid Eligibility Groups	Description and Citation	Medicaid Eligibility Group (MEG)	DSHP Benefit Package	DSHP Plus Benefit Package*	Alternative Benefits Plan Package
Qualified Pregnant Women, Mandatory Poverty Level Related Pregnant Women	§1902(a)(10)(A)(i)(III) and (IV) §1902(aa)(10)(A)(ii)(I), (IV) and (IX) §1931(b) and (d) 42 CFR 435.116 §1905(n)	If age 20 and under: DSHP TANF Children If age 21 and over: DSHP TANF Adults	X		
Qualified Children, Mandatory Poverty Level Infants, Children Aged 1-5 and Children Aged 6-18	§1902(a)(10)(A)(i)(III), (IV), (VI) and (VII) §1902(a)(10)(A)(ii)(I), (IV) and (IX) §1931(b) and (d) 42 CFR 435.118	If Title XIX: DSHP TANF Children If Title XXI: DSHP MCHIP	X		
SSI Adults without Medicare	§1902(a)(10)(A)(i)(I)(aa) 42 CFR 435.120	DSHP SSI Adults	X		
SSI Children without Medicare	§1902(a)(10)(A)(i)(I)	DSHP SSI Children	X		
Section 4913 Children – lost SSI because of the PRWORA disability definition	§1902(a)(10)(A)(i)(II)	DSHP SSI Children	X		
Parents and Caretaker Relatives	§1931(b) and (d) 42 CFR 435.110	If age 20 and under: DSHP TANF Children	X		

State Plan Mandatory Medicaid Eligibility Groups	Description and Citation	Medicaid Eligibility Group (MEG)	DSHP Benefit Package	DSHP Plus Benefit Package*	Alternative Benefits Plan Package
		If age 21 and over: DSHP TANF Adult			
Extended Medicaid due to Spousal support Collections	§408(a)(11)(B) §1931(c)(1) 42 CFR 435.115	If age 20 and under: DSHP TANF Children If age 21 and over: DSHP TANF Adults	X		
Transitional Medical Assistance	§408(a)(11)(A) §1902(a)(52) §1902(e)(1) §1925 §1931(c)(2)	If age 20 and under: DSHP TANF Children If age 21 and over: DSHP TANF Adult	X		
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care	§1902(a)(10)(A)(I) §473(b)(3) 42 CFR 435.145	DSHP TANF Children	X		
Continuous eligibility for pregnancy and 12 months Postpartum extension	§1902(e)(5) and (e)(6) 42 CFR 435.170 §1902(e)(16)	If age 20 and under: DSHP TANF Children If age 21 and over: DSHP TANF Adult	X		
Deemed newborns	§1902(e)(4) 42 CFR 435.117	DSHP TANF Children	X		
Working disabled under 1619(b)	§1902(a)(10)(A)(i)(II) §1905(q) §1619(b)	If age 20 and under: DSHP SSI Children If age 21 and over: DSHP	X		

State Plan Mandatory Medicaid Eligibility Groups	Description and Citation	Medicaid Eligibility Group (MEG)	DSHP Benefit Package	DSHP Plus Benefit Package*	Alternative Benefits Plan Package
		SSI Adults			
Disabled Adult Children	§1634(c)	If age 20 and under: DSHP SSI Children If age 21 and over: DSHP SSI Adults	X		
Institutionalized Individuals Continuously Eligible Since 1973	42 CFR 435.132	DSHP Plus State Plan		X	
Individuals Receiving Mandatory State supplements	42 CFR 435.130	If age 20 and under: DSHP SSI Children If age 21 and over: DSHP SSI Adults	X		
Individuals who become ineligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977 (Pickle amendment)	P.L. 94-566 Sec. 503 42 CFR 435.135	If age 20 and under: DSHP SSI Children If age 21 and over: DSHP SSI Adults	X		
Disabled widows/widowers ineligible for SSI due to an increase in OASDI	§1634(b) 42 CFR 435.137	DSHP SSI Adults	X		
Disabled widows/widowers ineligible for SSI due to early receipt of Social Security	§1634(d) 42 CFR 435.138	DSHP SSI Adults	X		
SSI Adults with Medicare	§1902(a)(10)(A)(i)(I)	DSHP PLUS State Plan		X	
SSI Children with Medicare	§1902(a)(10)(A)(i)(I)	DSHP PLUS +State Plan	X	X	
Former Foster Care Children	§1902(a)(10)(A)(i)(IX) 42 CFR 435.150	If age 20 and under: DSHP TANF	X		

State Plan Mandatory Medicaid Eligibility Groups	Description and Citation	Medicaid Eligibility Group (MEG)	DSHP Benefit Package	DSHP Plus Benefit Package*	Alternative Benefits Plan Package
		Children If age 21 and over: DSHP TANF Adults			
Individuals who lost eligibility for SSI/SSP due to an increase in OASDI benefits in 1972	42 CFR 435.134	DSHP SSI Adults	X		

State Plan Optional Medicaid Eligibility Groups	Description and Citation	MEG	DSHP Benefit Package	DSHP Plus Benefit Package	Alternative Benefit Plan Package
Adult Group ages 19-64	§1902(a)(10)(A)(i)(VIII) 42 CFR 435.119	DSHP Adult Group			X
TEFRA Children (Katie Beckett) Qualified Disabled Children under 19	§1902(e)(3)	DSHP SSI Children	X		
Individuals who would be eligible for SSI/OSS if not for residing in an institutional setting	§1902(a)(10)(A)(ii)(IV) 42 CFR 435.211	If age 21 and over: DSHP SSI Adults		X	
Children with Non-IV-E Adoption Assistance	§1902(a)(10)(A)(ii)(VIII) 42 CFR 435.227	DSHP TANF Children	X		
Optional State Supplement Recipients – 1634 States, and SSI Criteria States with 1616 Agreements individuals living in an adult residential care facility or assisted living facility	§1902(a)(10)(A)(ii)(IV) 42 CFR 435.232	If age 20 and under: DSHP SSI Children If age 21 and over: DSHP SSI Adults	X	X	
Optional State supplement – individuals who lose eligibility for Medicaid due	§1902(a)(10)(A)(ii)(IV) 42 CFR 435.232	If age 20 and under: DSHP SSI Children	X		

State Plan Optional Medicaid Eligibility Groups	Description and Citation	MEG	DSHP Benefit Package	DSHP Plus Benefit Package	Alternative Benefit Plan Package
to receipt of SSDI and are not yet eligible for Medicare Medical Assistance in Transition to Medicare (MAT)		If age 21 and over: DSHP SSI Adults			
Institutionalized individuals in Nursing Facilities who meet the Nursing Facility LOC criteria in place at the time of enrollment into the facility (with and without Medicare) even if they later do not meet the current LOC criteria	§1902(a)(10)(A)(ii)(V) 42 CFR 435.236 1905(a)	DSHP PLUS State Plan		X	
Ticket to Work Basic Group	§1902(a)(10)(A)(ii)(XV)	DSHP PLUS State Plan	X	X	
Out-of-State Former Foster Care Children	Optional Group of Individuals above 133 percent of the FPL §1902(a)(10)(A)(ii)(XX) 42 CFR 435.218	DSHP FFCY	X		

Demonstration Eligible Groups	Description and Citation	Income Standard	Resource Standard	MEG	DSHP Benefit Package	DSHP Plus Benefit Package
TEFRA-Like Children (Katie Beckett) using the "at-risk of NF" LOC criteria in place at time of enrollment	§1902(e)(3) Children, ages 18 or younger, who are disabled as described in section 1614(a) of the Act, who do not meet the NF LOC, but who in the absence of receiving care are "at-risk" of institutionalization and meet an "at-risk of NF" LOC. Use financial institutional eligibility rules for individuals who would not be eligible in the community because of community deeming rules.	Up to 250% of SSI Standard	$2,000	DSHP TEFRA-Like Children	X	
Aged and/or disabled categorically needy individuals over age 18 who	Use institutional eligibility and post eligibility rules for individuals who would not be eligible in the community	Up to 250% of SSI	$2,000 individual $3,000	DSHP PLUS HCBS		X

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

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

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

Table B. Eligibility Exclusions

Exclusions from DSHP and DSHP Plus	Description and Citation
Individuals participating in a PACE Program	§1934
Qualified Medicare Beneficiaries (QMB)	§1902(a)(10)(E)(i) §1902(r)(2) used to disregard all resources
Specified Low Income Medicare Beneficiary (SLMB)	§1902(a)(10)(E)(iii) §1902(r)(2) used to disregard all resources
Qualifying Individuals (QI)	§1902(a)(10)(E)(iv) §1902(r)(2) used to disregard all resources
Qualified and Disabled Working Individuals	§1902(a)(10)(E)(ii) §1902(r)(2) used to disregard all resources
Individuals in a hospital for 30 consecutive days* (acute care)	§1902(a)(10)(A)(ii)(V)
Presumptive Breast and Cervical Cancer for Uninsured Women	§1920B
Breast and Cervical Cancer Program for women	§1902(a)(10)(A)(ii)(XVIII)
Institutionalized individuals in an ICF/MR facility	§1902(a)(10)(A)(ii)(V)

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

eligibility matrix. During the period when the client may not enroll in the demonstration, their hospital stay will be covered fee for service.

18. **Eligibility and Post Eligibility Treatment of Income for DSHP Plus Individuals who are Institutionalized.** The state must follow the rules specified in the currently approved State plan for institutionalized DSHP Plus participants. All individuals receiving institutional services must be subject to post eligibility treatment of income rules set forth in section 1924 of the Act (for DSHP Plus individuals who are "institutionalized spouses" under section 1924(h)(1) of the Act) and 42 CFR 435.725 of the federal regulations.

19. **Maintenance Needs Allowances and Patient Liability.** For HCBS participants who are determined to be "217-like" (i.e., individuals who would not otherwise be eligible under an eligibility group covered under the state plan but who would be financially eligible if institutionalized), the state will apply the post-eligibility treatment-of-income calculation described in section 1924 of the Act (for such married HCBS participants) and 42 CFR 435.726. For such individuals who do not receive services in an Assisted Living Facility, the state will provide a maintenance needs allowance that is equal to the individuals' total income as determined under the post eligibility process, which includes income that is placed in a Miller Trust. For those HCBS participants that elect to receive services in an Assisted Living Facility, the state will provide a maintenance needs allowance set at the Adult Foster Care Rate, which is the SSI standard plus the Optional State Supplement amount.

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

20. **Eligibility for the PROMISE Program.** DSHP and DSHP Plus eligible beneficiaries and enrollees applying for services must be screened by the Division of Substance Abuse and Mental Health (DSAMH) using a standardized clinical and functional assessment developed for Delaware and based on national standards. See Attachment D for a detailed explanation of clinical and functional assessments that are used in the screening process.

21. **Eligibility for the Former Foster Care Youth.** Individuals eligible for this

demonstration are limited to "out-of-state former foster care youth" who are defined as individuals under age 26 that meet the following criteria:

a. Were in foster care under the responsibility of a state other than Delaware or a tribe in such other state when they turned age 18 (or such higher age as the state has elected for termination of Federal foster care assistance under title IV-E of the Act);
b. Were enrolled in Medicaid at the time of aging out of foster care;
c. Turned 18 on or before December 31, 2022;
d. Are now applying for Medicaid in Delaware; and,
e. Are not otherwise eligible for Medicaid.

22. Benefits and Cost-sharing provided under the Demonstration. Out-of-state former foster care youth will receive the same Medicaid State Plan benefits and be subject to the same cost-sharing requirements effectuated by the state for the mandatory title IV-E foster care youth eligibility category enacted by the Adoption Assistance and Child Welfare Act of 1980 (Pub. L. 96-272).

V. DSHP BENEFITS

23. DSHP Benefits. Benefits provided through this demonstration for the Medicaid managed care program are described below:

a. **DSHP Benefits.** As outlined in Table A, all mandatory and optional state plan and demonstration-eligible populations are entitled to receive all mandatory and optional services under the approved Medicaid state plan. These Medicaid state plan benefits are provided through a combination of contracts with managed care organizations or managed care delivery systems, as well as FFS, for specific services noted below.

b. **DSHP FFS Benefits.** The following state plan services are carved out from the Medicaid MCO benefit package and are paid on a FFS basis:
    i. Non-emergency transportation, except for emergency ambulance transportation (NEMT transportation broker);
    ii. Day services authorized by the Division of Developmental Disabilities Services
    iii. Medically necessary behavioral health services for children in excess of MCO plan benefit coverage, which is 30 visits for children;
    iv. Medically necessary behavioral health services for adults under the

PROMISE program;

v. Prescribed pediatric extended care; and
vi. Targeted case management (TCM), except as necessary to fulfill the requirements under section 1902(a)(84)(D) of the Act.

24. Alternative benefit plan. The Newly Eligible Group, made eligible under the state plan effective January 1, 2014, will receive benefits described in the state's approved alternative benefit plan (ABP) state plan amendment (SPA).

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

a. Emergency care;
b. Family planning services, including obstetrics and gynecology services; and
c. For female participants, the MCOs must allow direct access to women's health specialists within the health plan's network for covered care related to women's routine and preventive care.

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

27. Evidence-based Home Visiting Models. The state will provide access to home visiting to pregnant women and children through the Nurse Family Partnership (children up to the age of two) and Healthy Families Delaware (up through the child's third birthday) evidence-based home visiting programs.

28. Respite Benefit for Caregivers of Children and Young Adults. The state will provide a Medicaid-funded respite service for caregivers of children with complex medical conditions (CMC), including Autism Spectrum Disorder, severe emotional disorders and dual diagnoses of behavioral health or intellectual and developmental disabilities (IDD). The services will be provided in compliance with the HCBS assurances afforded in STC #44 and STC #52.

a**.** Types of pediatric respite available:

i. *In-home unskilled respite* – Provided in a child's place of residence, home of respite provider, or home of a friend or family member for children with unskilled care needs (i.e., supervision or assistance with ADLs and IADLs, supervision to assure health and welfare, or supervision of behavioral needs) who do not require services

by a qualified licensed or certified provider. Services provided to children with behavioral health needs are provided by a trained paraprofessional who is supervised by a licensed clinician.

ii. *In-home skilled respite* – Provided in a child's place of residence or home of a friend or family member for children with ongoing skilled medical and behavioral health needs that can only be provided by a qualified licensed or certified provider such as an RN/LPN. (e.g., suctioning, G-tube feeding). No FFP is available for the cost of room and board.

iii. *Out of home respite* – Skilled and unskilled support provided in a community setting or licensed facility, including but not limited to licensed childcare setting, nursing facility, hospital, residential treatment facility, foster home, Prescribed Pediatric Extended Care (PPEC), and group home.

iv. *Emergency respite* – A short-term service for children necessitated by an unplanned and unavoidable circumstance, such as a family emergency. Emergency respite can be provided in the home or in an out of home location. Prior approval is not required for emergency respite.

b. Limits and Assurances:

i. Pediatric respite is limited to 15 days or 285 hours per waiver year. If additional respite is required, the child or the child's representative may contact their MCO care coordinator to request additional hours based on medical necessity. - Emergency respite is limited to 72 hours per episode, with a maximum of six 72 seventy-two hours episodes per waiver year. Emergency respite is not included in the benefit limit. The child and/or child's representative gives final approval of where the respite is provided.

ii. Respite services are not intended to supplant routine care, including before and after school care.

iii. The child and/or child's representative gives final approval of where respite is provided, dependent on availability and consistent with the child's level of care needs.

iv. Medicaid will not pay for respite provided for the purpose of oversight of additional minor children in the home.

v. The cost of transportation is included in the rate paid to providers of these services.

vi. Federal financial participation is not available for the cost of room and board except when provided as part of services furnished in a facility approved by the State that is not a private residence.

c. Qualified Pediatric Respite Providers.

i. Individual Providers must meet the following qualifications:

- At least 18 years of age
- First aid certification
- CPR certification
- Training specific to address the child's needs
- Valid driver license (as needed)
- Criminal Background Check

ii. Licensed/Certified pediatric providers and agencies/facilities must meet all state requirements.

29. Self-directed personal care/attendant care for children – The state will allow a self-directed option for parents on behalf of children up to age 21, receiving State Plan personal care services (which are provided under the state plan home health benefit) and with a CMC, IDD, or behavioral health condition. The child's condition must result in the need for assistance with age-appropriate activities of daily living (ADL) and instrumental activities of daily living (IADL). Self-directed personal care/attendant care services for children includes assistance with ADLs (e.g., bathing, dressing, personal hygiene, transferring, toileting, skin care, eating and assisting with mobility) and IADLs (e.g. light housekeeping chores, shopping, meal preparation). Assistance with IADLs must be specified in the service plan and essential to the health and welfare of the participant based on the assessment of the Case Manager, provided to only the member and not for general utility within the household. A parent/guardian or other representative designated by the parent/guardian can direct this service on behalf of the member.

Provider Qualifications

a. Parents and caretakers may hire a neighbor, friend, or family member including a

legally responsible family member, who must meet all employee qualifications required under the state plan, as verified by the managed care plan. Legally responsible family members who provide self-directed personal care/attendant care service must designate another family member/representative to be responsible for directing care and signing time sheets. Legally responsible family members are limited to providing 40 hours of week of care.

b. The Self-Directed personal care/attendant care for children benefit will operate in accordance with the participant-direction requirements per STC 45.

30. **Postpartum Nutrition Supports Initiative.** Eligible Medicaid beneficiaries in their postpartum period may receive the nutritional equivalent of up to two meals per day, up to eighty diapers per week, and up to one pack of baby wipes per week delivered for the first twelve weeks of the beneficiary's postpartum period. This initiative will be based on the beneficiary's needs and will not constitute a full nutritional regimen. The nutrition supports may be adjusted for family size.

31. **Eligibility.** To the qualify for the Postpartum Nutrition Supports Initiative, the MCO coordinators will screen for eligibility during the pregnancy period or during the postpartum period.

32. **Contingency Management Overview.**
    a. Beginning no earlier than July 1, 2024, DMMA will implement a new contingency management benefit for qualifying beneficiaries with a stimulant use disorder and/or opioid use disorder (OUD) in eligible provider settings.

    b. Under the demonstration, the contingency management benefit will be available to qualified beneficiaries who meet the eligibility requirements described below, who may receive services from a participating provider approved by DMMA to provide this benefit.

33. **Eligibility.** To qualify for the contingency management benefit, a beneficiary must meet the following conditions:
    a. Age 18 or older diagnosed with a stimulant disorder to qualify for the twenty-four-week program; or

    b. Age 18 or older, pregnant, or up to 12 months postpartum diagnosed with an OUD to qualify for the sixty-four-week program;

c. Be assessed and determined to have a substance use disorder for which the contingency management benefit is medically necessary and appropriate based on the fidelity of treatment to the evidence-based intervention;

d. Be assessed and determined to have a stimulant use disorder and/or opioid use disorder as the primary diagnosis for which the contingency management benefit is medically necessary and appropriate based on the fidelity of treatment to the evidence-based intervention. The presence of additional substance use disorders and/or diagnoses does not disqualify an individual from receiving contingency management services;

e. Not be enrolled in another contingency management program for stimulant use disorder or OUD;

f. Receive services from an eligible provider that offers the contingency management benefit in accordance with DMMA policies and procedures; and

g. Not receive contingency management as an alternative for medication treatment for other substance use disorders for which medication treatment is a medically appropriate option (e.g. alcohol use disorder).

34. Service Description.

a. The contingency management benefit provides a series of motivational incentives for meeting treatment goals. The motivational incentives may consist of cash equivalents, e.g., gift cards of low retail value, with restrictions placed on the incentives so they are not used to purchase cannabis, tobacco, alcohol, over-the-counter preparations containing possible intoxicants such as dextromethorphan, weapons (including firearms/ and ammunition, gambling-related items such as lottery tickets, pornographic materials or additional items as identified by the state. The motivational incentives are consistent with evidence-based clinical research for treating a stimulant use disorder and/or opioid use disorder as described below. These motivational incentives are central to contingency management, based on the best available scientific evidence for treating a stimulant use disorder and not as an inducement to use other medical services.

b. The contingency management benefit uses an evidence-based approach that recognizes and reinforces individual positive behavior change consistent with

substance non-use or treatment adherence. The contingency management benefit provides motivational incentives for treatment adherence or non-use of stimulants as evidenced by negative point of care, rapid, Clinical Laboratory Improvement Amendments (CLIA)-waived drug tests.

c. Contingency management is offered along with other therapeutic interventions, such as cognitive behavioral therapy, that meet the definition of rehabilitative services as defined by 1905(a) of the Act and 42 CFR 440.130(d). The provision of the contingency management benefit is not conditioned on a beneficiary's engagement in other psychosocial services.

d. For purposes of this demonstration, these motivational incentives are used to reinforce objectively verified recovery behaviors using a clinically appropriate contingency management protocol consistent with evidence-based research. Consequently, neither the Federal anti-kickback statute (42 U.S.C. § 1320a-7b(b), "AKS") nor the civil monetary penalty (CMP) provision prohibiting inducements to beneficiaries (42 U.S.C. § 1320a-7a(a)(5), "Beneficiary Inducements CMP") would be implicated.

e. The contingency management benefit consists of a set of modest motivational incentives available for beneficiaries who meet treatment goals. Under the benefit, a beneficiary will be limited in motivational incentives during the course of a contingency management treatment episode as detailed in the Procedures and Protocols in Attachment K.

    i. To qualify for a motivational incentive under the contingency management benefit, a beneficiary must be a participant in the twenty-four-week program for stimulant use disorder and demonstrate non-use of stimulants, or be a participant in the sixty-four-week program for opioid use disorder and demonstrate treatment adherence. By participating in the programs, a beneficiary can receive incentive payments for each visit where they test negative for the substance being treated for the stimulant use disorder program or demonstrate treatment adherence for the opioid use disorder program.

    ii. The size, nature, and distribution of all contingency management motivational incentives shall be determined in strict accordance with DMMA procedures and protocols, listed in Attachment K . These procedures and protocols will be based on established clinical research for contingency management. The following guardrails shall ensure the

integrity of the contingency management benefit and mitigate the risk of fraud, waste, or abuse associated with the motivational incentive:

1. Providers have no discretion to determine the size or distribution of motivational incentives, which will be determined by DMMA's schedule of incentive payments.
2. Motivational incentives will be managed through an incentive management tool that includes safeguards against fraud and abuse. These safeguards will be detailed in DMMA's guidance and listed in the Contingency Management Protocol Attachment K.
3. To calculate and generate the motivational incentives in accordance with the schedule in Attachment K, providers shall enter the outcome of the test of the beneficiary receiving the contingency management benefit into an incentive management tool.

iii. The aggregate annual amount of incentive payments that an individual can receive by participating in the contingency management program shall be determined by DMMA and memorialized in statewide clinical policy.

iv. There is not a limit on the number of times a beneficiary can participate in the programs.

35. Eligible Contingency Management Providers.

a. The contingency management benefit will be delivered by eligible providers that meet specified programmatic standards and agree to deliver the contingency management benefit in strict accordance with standardized procedures and protocols that will be detailed in DMMA guidance and listed in the Contingency Management Protocol Attachment K, and other applicable laws, regulations, and requirements.

b. To be eligible to offer the contingency management benefit, a provider shall offer the benefit in strict accordance with DMMA standards that will be outlined in DMMA guidance included in Attachment K and shall meet the following requirements:

i. Must be a Medicaid enrolled provider;
ii. Must be enrolled in Delaware Medicaid, certified to provide Medicaid services, including without limitation primary care, behavioral health and substance use service providers;
iii. Require the staff providing or overseeing the contingency management benefit to participate in contingency management-specific training and participate in ongoing training, and technical assistance offered by DMMA;
iv. Undergo a readiness review by DMMA to ensure that they are capable of offering the contingency management benefit in accordance with DMMA standards that will be detailed in DMMA guidance;
v. Shall comply with any billing and data reporting requirements established by DMMA to support research, evaluation, and performance monitoring efforts, including but not limited to satisfactory claims submission, data and quality reporting, and survey participation; and must employ or contract with a sufficient number of licensed mental health professionals that have SUD specific scope and training as further specified in STC 36.c, for provision of services and ensure:

1. They maintain their licensure in accordance with applicable laws and regulations governing their licensure; and

2. They provide services to beneficiaries receiving the contingency management benefit within the scope of their licensure.

c. The following practitioners delivering care at eligible providers can deliver the contingency management benefit through activities, such as administering point of-care drug tests, informing beneficiaries of the results of the evidence/point of care drug test, entering the results into a software program, providing educational information, and distributing motivational incentives, as part of the contingency management benefit:

i. Licensed mental health professional with SUD specific scope and training (e.g., licensed clinical social worker (LCSW), licensed professional counselors (LPCs) and licensed addiction counselors (LACs); or

ii. Trained staff with appropriate supervision by licensed health professionals.

36. Program Oversight.

a. DMMA shall monitor the ongoing performance, including fidelity of treatment to the evidence-based practice, of contingency management providers and identify and support providers requiring further training or technical assistance in accordance with DMMA set standards, to be outlined in DMMA guidance.

b. DMMA will provide training, technical assistance and monitoring to providers throughout the implementation process. The training and technical assistance will be provided through a qualified contractor designated by DMMA, and will include staff training, provider readiness reviews, and ongoing technical assistance during the first phase of the pilot.

37. Changes in Medicaid Policy on Contingency Management. In accordance with STC 3, nothing in this demonstration absolves the state of Delaware from being subject to future requirements on contingency management set forth in Medicaid law, regulation, or policy and the state would otherwise need to come into compliance with such requirements.

38. Contingency Management Evaluation. In alignment with the Diamond State Health Plan demonstration evaluation requirements outlined in Section XVII of these STCs, DMMA will conduct an evaluation of the effectiveness of the Contingency Management program to assess its overall effectiveness, including cost effectiveness of these services, and its effects on beneficiary health and recovery outcomes. To the extent feasible, the state will conduct the evaluation to support assessment stratified by stimulant use disorder, opioid use disorder, and other types of SUD.

VI. DSHP PLUS BENEFITS

39. Eligibility for DSHP Plus HCBS Benefits. DSHP Plus provides HCBS LTSS as identified in Table E to eligible individuals as outlined in Table A. Medical and/or

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

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

Table C. DSHP Plus HCBS

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

41. Option for Participant Direction of DSHP Plus HCBS Services. DSHP Plus

participants who elect self-directed care must have the opportunity to have choice and control over how self-directed DSHP Plus HCBS services are provided and who provides the service. Member participation in participant direction is voluntary, and members may participate in or withdraw from participant direction at any time.

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

b. **Participant Direction by Representative.** The participant who self-directs the DSHP Plus HCBS service may appoint a volunteer designated representative to assist with or perform employer responsibilities to the extent approved by the participant. DSHP Plus HCBS services may be directed by a legal representative of the participant. DSHP Plus HCBS services may be directed by a non-legal representative freely chosen by an adult participant. A person who serves as a representative of a participant for the purpose of directing DSHP Plus HCBS services cannot serve as a provider of DSHP Plus HCBS services for that participant.

c. **Participant Employer Authority.** The participant (or the participant's representative) must have decision-making authority over workers who provide DSHP Plus HCBS.

    i. Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide DSHP Plus HCBS. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting

employer-related functions.

ii. Decision Making Authorities. The participant exercises the following decision-making authorities: Recruit staff, select staff from worker registry, hire staff as common law employer, verify staff qualifications, obtain criminal history and/or background investigation of staff, specify additional staff qualifications based on participant needs and preferences, evaluate staff performance, verify time worked by staff and approve time sheets, and discharge staff.

d. **Disenrollment from Participant-Direction.** A participant may voluntarily disenroll from the self-directed option at any time and return to a traditional service delivery system through the DSHP Plus MCOs. To the extent possible, the member shall provide his/her DSHP Plus HCBS provider ten (10) days advance notice regarding his/her intent to withdraw from participant direction. A participant may also be involuntarily dis-enrolled from the self-directed option for cause, if continued participation in the participant-directed services option would not permit the participant's health, safety, or welfare needs to be met, or the participant demonstrates the inability to self-direct by consistently demonstrating a lack of ability to carry out the tasks needed to self-direct personal care services, or if there is fraudulent use of funds such as substantial evidence that a participant has falsified documents related to participant directed services. If a participant is terminated voluntarily or involuntarily from the self-directed service delivery option, the MCO must transition the participant to the traditional agency direction option and must have safeguards in place to ensure continuity of services.

VII. Substance Use Disorder (SUD) Program

42. Substance Use Disorder Program. Effective upon CMS' approval of the SUD Implementation Protocol, the demonstration benefit package for Delaware Medicaid recipients will include SUD treatment services, including short term residential services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903 of the Act. The state will be eligible to receive FFP for Delaware Medicaid recipients who are short-term residents in IMDs under the terms of this demonstration for coverage of medical assistance, including SUD benefits that would otherwise be matchable if the beneficiary were not residing in an IMD. Delaware will must aim for a statewide average length of stay of 30 days in residential treatment settings, to be monitored pursuant to the SUD Monitoring Protocol J as outlined in STC 77 below, to ensure short-term residential treatment stays. Under this

demonstration, beneficiaries will have access to high quality, evidence-based SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions.

The coverage of SUD treatment services and withdrawal management during short term residential and inpatient stays in IMDs will expand Delaware's current SUD benefit package available to all Delaware Medicaid recipients as outlined in Table F. Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

Table D: Delaware SUD Benefits Coverage with Expenditure Authority

SUD Benefit	Medicaid Authority	Expenditure Authority
Outpatient Services	State plan (Individual services covered)	
Intensive Outpatient Services	State plan (Individual services covered)	
Residential Treatment	State plan (Individual services covered)	Services provided to individuals in IMDs
Medically Supervised Withdrawal Management	State plan	Services provided to individuals in IMDs
Medication-Assisted Treatment (MAT)	State plan	Services provided to individuals in IMDs

The state attests that the services indicated in Table F, above, as being covered under the Medicaid state plan authority are currently covered in the Delaware Medicaid state plan.

43. SUD Implementation Plan and Health IT Plan

a. SUD Implementation Plan. The state must submit a SUD Implementation Plan within 90 calendar days after approval of the SUD program under this demonstration. The state may not claim FFP for services provided in IMDs until CMS has approved the Implementation Plan. Once approved, the Implementation Plan will be incorporated into the STCs, as Attachment I, and once incorporated, may be altered only with CMS approval. After approval of the SUD Implementation Plan, FFP will

be available prospectively, not retrospectively. Failure to submit an Implementation Protocol will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SUD program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral.

At a minimum, the SUD Implementation Plan must describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of the SUD component of this demonstration program:

i. **Access to Critical Levels of Care for Opioid Use Disorder and other SUDs:** Service delivery for new benefits, including residential treatment and withdrawal management, within 12-24 months of SUD program demonstration approval;

ii. **Use of Evidence-based SUD-specific Patient Placement Criteria:** Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of SUD program demonstration approval;

iii. **Patient Placement:** Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of SUD program demonstration approval;

iv. **Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities:** Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in Title 16 Delaware Health and Social Services, Delaware Administrative Code, Section 6001, 4.1. The state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM

Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of SUD program demonstration approval;

v. **Standards of Care:** Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of SUD program demonstration approval;

vi. **Standards of Care:** Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of SUD program demonstration approval;

vii. **Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for SUD:** An assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of SUD program demonstration approval;

viii. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD:** Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;

ix. **SUD Health IT Plan:** Implementation of the milestones and metrics as detailed in STC 46(g) [or Attachment I, if included as attachment]; and

x. **Improved Care Coordination and Transitions between levels of care:** Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of SUD program demonstration approval.

b. SUD Health Information Technology (Health IT). The state must provide CMS with an assurance that it has a sufficient health IT infrastructure/ "ecosystem" at every appropriate level (i.e., state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration-or it will submit to CMS a plan to develop the infrastructure/capabilities. This "SUD Health IT Plan," or assurance, must be included as a section of the state's "Implementation Plan" (see STC 43 (a)) to be approved by CMS. The SUD Health IT Plan must detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The SUD Health IT Plan must also be used to identify areas of SUD health IT ecosystem improvement.

i. The SUD Health IT section of the SUD Implementation Protocol must include implementation milestones and dates for achieving them (see Attachment I).

ii. The SUD Health IT Plan must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) "Health IT" Plan.

iii. The SUD Health IT Plan must describe the state's goals, each DY, to enhance the state's prescription drug monitoring program's (PDMP)[3]

iv. The SUD Health IT Plan must address how the state's PDMP will enhance ease of use for prescribers and other state and federal stakeholders.[4] This must also include plans to include PDMP interoperability with a statewide, regional, or local Health Information Exchange. Additionally, the SUD Health IT Plan must describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients' history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.

v. The SUD Health IT Plan must, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the SUD Health IT Plan must describe current and future capabilities regarding PDMP queries-and the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state will must also indicate current efforts or plans to

[3] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.
[4] *Ibid*.

develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

vi. The SUD Health IT Plan must describe how the activities described in (a) through (e) above will support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.[5]

vii. In developing the SUD Health IT Plan, states should use the following resources.

1. States may use resources at HealthIT.gov (https://www.healthit.gov/playbook/opioid-epidemic-and-health-it/) in "Section 4: Opioid Epidemic and Health IT."
2. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.
3. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP plans and, more generally, to meet the goals of the demonstration.

g. The state must include in its Monitoring Protocol (see STC 73)) an approach to monitoring its SUD Health IT Plan which will include performance metrics to be approved in advance by CMS.

h. The state must monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines-and report on its progress to CMS within its Annual Reports (see STC 74).

i. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory-Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

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[5] Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morbidity and Mortality Weekly Rep 2017; 66.

i. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state must use the federally recognized standards.
ii. Where there are opportunities at the state-and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state must use the federally recognized ISA standards.

VIII. PROMISE BENEFITS

44. PROMISE Enrollee Access to DSHP and DSHP Plus Benefits. Individuals enrolled in PROMISE will receive all of their DSHP or DSHP Plus state plan benefits through the MCOs, just as the individuals had before enrollment in PROMISE. However, DSHP beneficiaries who are enrolled in PROMISE, will have a Department of Substance Abuse and Mental Health (DSAMH) counselor as their primary case manager. DSHP Plus beneficiaries will continue to have the MCO case manager act as their primary; the DSAMH counselor will be the secondary case manager. Individuals enrolled in PROMISE and eligible for DSHP and DSHP Plus but not yet enrolled in an MCO may receive all of their state plan benefits through FFS while awaiting enrollment in the MCO.

45. PROMISE Benefits. Beneficiaries enrolled in PROMISE receive all of the following non-state plan benefits through the program (definitions of these services are found in Attachment D):

a. Benefits counseling
b. Case management
c. Community-based residential alternative supports that exclude assisted living
d. Community transition services
e. CPST/PSR and other services by non-licensed clinic staff including evidence-based practices, such as assertive community treatment (ACT) and intensive case management (ICM)
f. Financial coaching
g. Non-medical transportation
h. Nursing
i. Peer supports
j. Personal care
k. Respite
l. Skill-building for individual activities of daily living/chore
m. Supported employment (both individual and small group)

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

IX. COST SHARING

46. Co-payments will be charged to all DSHP and DSHP Plus Managed Care enrollees as stipulated in the state plan. Standard Medicaid exemptions from cost-sharing, such as family planning services, as stipulated in 42 CFR. 447.56, apply to the demonstration.

X. ENROLLMENT

47. DSHP and DSHP plus Mandatory Enrollment.

a. **Enrollment.** The state may mandatorily enroll individuals pursuant to 42 CFR 438.54(d) served through this demonstration in managed care programs to receive DSHP and DSHP Plus benefits pursuant to Sections V, VI and VIX of the STCs.

b. **Notice Requirement for a Change in Network.** The state must provide notice to CMS as soon as it becomes aware of (or at least 90 days prior if possible) a potential change in the number of plans available for choice within an area, or any other changes impacting proposed network adequacy.

48. PROMISE Enrollment. DSAMH coordinates enrollment into PROMISE. A DSAMH care manager will arrange to meet the beneficiary and assess the beneficiary's eligibility for the PROMISE program based on the standardized assessment tool in Attachment D. If the individual meets the criteria for enrollment into the program, the individual can choose whether to enroll in the program, as enrollment is strictly voluntary. Individuals enrolled in this program will receive the benefits outlined in Attachment D.

XI. DELIVERY SYSTEMS

49. Managed Care Requirements. The state, its MCOs and any subcontractor delegated to perform activities under the managed care contract must comply with the managed care regulations published at 42 CFR Part 438, except as explicitly waived herein. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR 438.4 through 438.8.

50. Managed Care Benefit Package. Individuals enrolled in any managed care plan within the state must receive from the managed care plan the benefits as identified in Sections V and VI of the STCs.

51. Public Contracts. Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, must not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

52. Requirements for Quality Measurement and Performance Improvement. The state must meet all the requirements of 42 CFR Part 438 Subpart E.

53 Advisory Committee as required in 42 CFR 438.70. The state must maintain for the duration of the demonstration a managed care advisory group comprised of individuals and interested parties impacted by the demonstration's use of managed care, regarding the impact and effective implementation of these changes to seniors and persons with disabilities. Membership on this group should be periodically updated to ensure adequate representation of individuals receiving LTSS.

54. PROMISE and MCO Care Coordination. The state must assure that the MCOs coordinate, to the maximum extent possible, all services provided by the MCO (primary, acute, and any state plan behavioral health services) with the enhanced behavioral health services provided FFS by the PROMISE program.

XII. HCBS SERVICE DELIVERY AND REPORTING REQUIREMENTS

55. Integration of HCBS assurances within the State Quality Strategy. DSHP Plus and PROMISE. The state is required to integrate the Section 1915(c) waiver assurances and program requirements into DSHP Plus (as appropriate for a managed long-term service and supports program, consistent with the 42 CFR Part 438 requirements) and the 1915(i) SPA assurances and program requirements into PROMISE. The state is expected to implement systems that measure and improve its performance to meet the waiver assurances set forth in 42 CFR 441.301 and 441.302 and the state, or its EQRO, must monitor and annually evaluate the MCO's performance on these assurances as part of its external quality review.

56. Quality Improvement Strategy for 1915(c) or 1915(i) approvable HCBS Services For services that could have been authorized to individuals under a 1915(c) waiver or under a 1915(i) HCBS State plan, the state must submit a Quality Improvement Strategy (QIS) and performance measures to CMS for review and approval within 90 days following approval of the demonstration extension. For DSHP Plus, the state may use the metrics required at 42

CFR 438.340 where applicable. The state must identify the performance measures in its Managed Care Sate Quality Strategy that demonstrate the assurances and subassuarances at 42 CFR 441.301 and 441.302 as listed below. For DSHP Plus HCBS reporting, these performance measures must only include the HCBS population. The state's, QIS and performance measures must encompass LTSS specific measures set forth in the federal managed care rule at 42 CFR 438.330 (for DSHP Plus) and should also reflect how the state will assess and improve performance to demonstrate compliance with applicable federal waiver assurances set forth in 42 CFR 441.301 and 441.302 as follows:

a. **Administrative Authority**. A performance measure should be developed and tracked for any authority that the State Medicaid Agency delegates to another agency, unless already captured in another performance measure.

b. **Level of Care or Eligibility based on 1115 Requirements.** Performance measures are required for the following: applicants with a reasonable likelihood of needing services receive a level of care determination or an evaluation for HCBS eligibility either by the State, or as a contractual requirement, by the MCO or PROMISE program, the processes for determining level of care or eligibility for HCBS are followed as specified by the state, either through the state's own processes, or as a contractual requirement, by the MCO documented, and the HCBS eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved demonstration.

c**. Person-Centered Planning and Individual Service Plans.** The state must demonstrate it has designed and implemented an effective system for reviewing the adequacy of service plans for HCBS participants. The state must have performance measures to track: choice of waiver services and providers, that service plans address all assessed needs and personal goals, that service plans are updated / revised at least annually or when warranted by changes in the participant's needs, and that services are delivered in accordance with the service plan including the type, scope, amount, duration, and frequency specified in the service plan.

i.

d. **Qualified Providers**. The state must have performance measures to track that providers meet licensure/certification standards, that non-certified providers are monitored to assure adherence to demonstration requirements, and that the state verifies that training is given to providers in accordance with the demonstration.

e. **Financial Accountability.** The state must have performance measures to demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the HCBS program. For DSHP Plus, this requires the state to demonstrate actuarial soundness on an annual basis pursuant to 42 CFR Part 438.

f. **Health and Welfare.** The state must demonstrate it has designed and implemented an effective system for assuring HCBS participants' health and welfare. The state must have one or more performance measures that track that: the MCO contract and PROMISE program shall require the MCO and PROMISE staff to, on a continuous basis, identify, address, and seek to prevent instances of abuse, neglect, exploitation; and unexplained deaths; that an incident management system is in place that effectively resolves incidents and prevents further singular incidents to the extent possible; that state policies and procedures for the use or prohibition of restrictive interventions are followed; and, that the state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved demonstration.

g. HCBS Settings Requirements. The state must have performance measures to demonstrate that settings meet the home and community-based setting requirements in accordance with 42 CFR 441.301(c)(4).

The state will submit a report to CMS following receipt of an Evidence Request letter and report template from the Division of HCBS Operations & Oversight (DHCBSO) no later than 21 months prior to the end of the approved waiver demonstration period that includes evidence on the status of the approved HCBS quality assurances and measures that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers. Following receipt of the state's evidence report, the DHCBSO will issue a draft report to the state and the state will have 90 days to respond. The DHCBSO will evaluate the evidentiary report to determine whether the assurances have been met and will issue a final report to the state 60 days following receipt of the state's response to the draft report.

57. The state must report annually the deficiencies found during the monitoring and evaluation of the HCBS performance measures and assurances, an explanation of how these deficiencies have been or are being corrected, as well as the steps that have been taken to ensure that these deficiencies do not reoccur. The state must also report on the number of substantiated

instances of abuse, neglect, exploitation and/or death, the actions taken regarding the incidents and how they were resolved. For PROMISE, submission is due no later than 6 months following the end of the demonstration year. For DSHP Plus, submission can be with the annual 1115 monitoring report.

58. For the PROMISE program, the state must annually report to CMS the actual number of unduplicated individuals served and the estimated number of individuals to be served for the following year no later than 90 days post the end of each Demonstration Year.

59. **Person centered planning:**

The MCO contract and PROMISE program shall require the use of a person-centered and directed planning process as required by 42 CFR 441.301(c)(1) and per 1915(c), and 42 CFR 441.725(c) and per 1915(i) and intended to identify the strengths, capacities, and preferences of the enrollee as well as to identify an enrollee's long term care needs and the resources available to meet these needs, and to provide access to additional care options as specified by the contract. The person-centered plan is developed by the participant with the assistance of the team and those individuals, such as family, friends, and professionals the participant chooses to include. The individual will have informed choices about treatment and service decisions. The plan includes the services and supports that the participant needs to live in the community.

a. The MCO contract and PROMISE program shall require the written person-centered service plan meets federal requirements at 42 CFR 441.301(c)(2) as per 1915(c) and 42 CFR 441.725(b) as per 1915(i) so that service plans must address all enrollees' assessed needs (including health and safety risk factors), preferences, choices abilities and personal goals and the strategies to address them.

b. The MCO contract and PROMISE program shall require that a process is in place that permits participants to request a change to the person-centered plan if the participant's circumstances necessitate a change. The MCO contract and PROMISE program shall require that all service plans are updated collaboratively and/or revised at least annually or when warranted by changes in the enrollee's needs and involve an ongoing commitment to the participant.

c. The MCO contract and PROMISE program shall require development of a back-up plan to ensure that needed assistance will be provided in the event that the regular services and supports identified in the individual service plan are temporarily unavailable. The back-up plan may include other individual assistants or services.

d. The MCO contract and PROMISE program shall require that services be delivered in accordance with the service plan, including the type, scope, amount, and frequency.

e. The MCO contract and PROMISE program shall require that enrollees receiving HCBS services have a choice of provider within the MCO's network and PROMISE program, as applicable.

f. The MCO contract and PROMISE program shall require policies and procedures for the MCO and PROMISE performance improvement process to monitor appropriate implementation of the individual service plans.

g. The MCO contract and PROMISE program shall utilize the state established minimum guidelines as outlined in the approved MCO contracts and PROMISE manuals regarding:

- The individuals who develop the person-centered service plan (and their requisite qualifications);
- The individuals who are expected to participate in the plan development process;
- Types of assessments that are conducted as part of the service plan development process;
- How participants are informed of the services available to them;

60. **Fair Hearings.**

a. All enrollees must have access to the state fair hearing process as required by 42 CFR 431 Subpart E. In addition, the requirements governing MCO appeals and grievances in 42 CFR 438 Subpart F shall apply for MCO covered benefits.

b. The MCO contract shall require the MCO to make whatever reasonable accommodations are necessary to ensure that enrollees have a meaningful opportunity to exercise their appeal and grievance rights.

61. **Provider Qualifications:**

a. The MCO provider credentialing requirement in 42 CFR 438.214 and HCBS provider qualification requirements in PROMISE shall apply to all HCBS providers. If the state wishes to change provider qualification standards from those that exist under waivers #0136 and #4159, the state must reach agreement with CMS to do so and ensure that the new standards preserve health and welfare. The state is required to report any changes in provider qualification standards as a part of the quarterly monitoring calls and quarterly reports pursuant to STCs 65 and 67.

b. To the extent that the MCO's credentialing policies and procedures do not address non-licensed non-certified providers, the MCO shall create alternative mechanisms to ensure the health and safety of enrollees.

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

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

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

65. HCBS Conflict of Interest. The state assures compliance with the HCBS conflict of interest protections at 42 CFR 441.301(c)(1)(vi) and 441.730(b). The state agrees that the entity that authorizes the services is external to the agency or agencies that provide the HCBS services. The state also agrees that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.

The state, either directly or through its MCO contracts must ensure that participants' engagement and community participation is supported to the fullest extent desired by each participant.

Beneficiaries may change managed care plans if their residential or employment support provider is no longer available through their current plan.

Each beneficiary eligible for long term services and supports will have informed choice on their option to self-direct LTSS, have a designated representative direct LTSS on their behalf, or select traditional agency-based service delivery. Both level of care and person-centered service planning personnel will receive training on these options.

66. Electronic Visit Verification System (EVV): The state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) and home health services in accordance with section 12006 of the 21st Century CURES Act.

67. HCBS Settings Requirements. The state must assure compliance with the characteristics of HCBS settings as described in 42 CFR 441.301(c)(4) in accordance with implementation/effective dates as published in the Federal Register.

XIII. GENERAL MONITORING AND REPORTING REQUIREMENTS

68. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singularly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

a. The following process will be used: 1) Thirty (30) calendar days after the deliverable(s) were due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (c) below; or 2) Thirty (30) calendar days after CMS has notified the state in writing that the deliverable(s) were not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable(s) into alignment with CMS requirements.

b. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

c. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay, the steps the state has taken to address such issues(s), and the state's anticipated date of submission. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action plan submitted by the state as an interim step before applying the deferral, if correction action is proposed in the state's written extension request.

d. If CMS agrees to an interim corrective process in accordance with subsection (c) above, and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) that meet the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

e. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

69. Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress toward Milestones. Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Protocol and the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

70. Submission of Post-approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

71. Electronic Submission of Reports. The state must submit all monitoring and evaluation report deliverables required in these STCs (e.g., quarterly reports, annual reports, evaluation reports) electronically, through CMS' designated electronic system.

72. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 waiver reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all 1115 demonstration, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

73. SUD Monitoring Protocol. The state must submit to CMS a draft Monitoring Protocol for the SUD programs authorized by this demonstration within 150 calendar days after approval of the demonstration extension. The SUD Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. The state must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS' comments, if any. Once approved, the Monitoring Protocol will be incorporated into the STCs, as Attachment J. Progress on the performance measures identified in the SUD Monitoring Protocol must be reported via the Quarterly and Annual Monitoring Reports. Components of the SUD Monitoring Protocol include:

a. An assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in Attachment C and information relevant to the state's Health IT Plan described in STC 47 (b);

b. A description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general monitoring and reporting requirements described in Section VIII (Monitoring and Reporting Requirements) of the demonstration; and

c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

74. Monitoring Reports. The state must submit three Quarterly Monitoring Reports and one Annual Monitoring Report each demonstration year (DY). The fourth quarter information that would ordinarily be provided in a separate Quarterly Monitoring Report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Report (including the fourth-quarter information) is due no later than ninety (90) calendar days following the end of the DY. The state must submit a revised Monitoring Report within sixty (60) calendar days after receipt of CMS's comments, if any. The reports will

include all required elements as per 42 CFR 431.428 and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Quarterly and Annual Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve and be provided in a structured manner that supports federal tracking and analysis.

a. **Operational Updates -** Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key operational and other challenges, underlying causes of challenges, how challenges are being addressed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. legislative updates; and descriptions of any public forums held. In addition, Monitoring Report should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. The Monitoring Reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. **Performance Metrics.** The performance metrics will provide data to demonstrate how the state is progressing toward meeting the goals and milestones – including relative to their projected timelines – of the demonstration's program and policy implementation and infrastructure investments, and transitional non-service expenditures, as applicable and must cover all key policies under this demonstration. Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as beneficiaries' outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction surveys, if conducted, as well as grievances and appeals.

   The demonstration's metrics reporting must cover categories including, but not limited to: enrollment and renewal, including access to providers, utilization of services, and quality of care and health outcomes. The state must undertake robust reporting of quality of care and health outcomes metrics aligned with the demonstration's policies and objectives to be reported for all demonstration populations. Such reporting must also be stratified by key demographic

subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, and geography) and by demonstration component, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities. To that end, CMS underscores the importance of the state's reporting of quality of care and health outcomes metrics known to be important for closing key equity gaps in Medicaid/CHIP (e.g., NQF "disparities-sensitive" measures) and prioritizing key outcome measures and their clinical and non-clinical (i.e., social) drivers of health. In coordination with CMS, the state is expected to select such measures for reporting in alignment with a critical set of equity-focused measures CMS is finalizing as part of its upcoming guidance on the Health Equity Measure Slate, as applicable to the demonstration initiatives and populations. If needed, the state may submit an amendment to its monitoring plan no more than 150 days after receiving the final Health Equity Measure Slate from CMS to incorporate these measures.

i. For the SUD component, the state's monitoring must align with the CMS approved SUD Monitoring Protocol (see STC 77),) and will cover metrics in alignment with assessment of need and qualification for SUD treatment services and the demonstration's six milestones as outlined in the State Medicaid Director Letter (SMDL) dated November 1, 2017 (SMDL #17- 003). [6]

ii. For the Contingency Management program, the state's reporting must cover metrics for domains including but not limited to enrollment, overall incentives provided, and average incentives provided per beneficiary during the treatment phase as well as types and counts of aftercare and treatment services rendered during the aftercare phase.

iii. In addition to the enrollment and renewal metrics that support tracking Medicaid churn, systematic monitoring of the continuous eligibility policy must – at a minimum – capture data on utilization of preventive care services, including vaccination among

[6] SMDL #17-003, Strategies to Address the Opioid Epidemic. Available at: https://www medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

populations of focus, and utilization of costlier and potentially avoidable services, such as inpatient hospitalizations and nonemergent use of emergency departments.

In addition, if the state, health plans, or health care providers will contract or partner with organizations to implement the demonstration, the state must use monitoring metrics that track the number and characteristics of contracted or participating organizations and corresponding payment-related metrics.

The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. **Budget Neutrality and Financial Reporting Requirements**. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately on the Form CMS-64.
d. **Evaluation Activities and Interim Findings.** Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.
e. **SUD Health IT Plan.** The state must include a summary of progress made in regard to SUD Health IT Plan requirements outlined in STC 47(b).

75. SUD Mid-Point Assessment. The state must contract with an independent entity to conduct an independent Mid-Point Assessment by December 31, 2026. This timeline will allow for the Mid-Point Assessment Report to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. In addition, if applicable, the state should use the prior approval period experiences as context, and conduct the Mid-Point Assessment in light of the data from any such prior approval period(s). In the design, planning and conduct of the Mid- Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of MCOs, health care providers

(including SUD treatment providers), beneficiaries, community groups, and other key partners.

a. The state must require that the assessor provide a Mid-Point Assessment Report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the report to CMS no later than 60 calendar days after December 31, 2026. If requested, the state must brief CMS on the report. The state must submit a revised Mid-Point Assessment Report within 60 calendar days after receipt of CMS's comments, if any.

b. For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS modifications to the SUD Implementation Plan and SUD Monitoring Protocol for ameliorating these risks. Modifications to the Implementation, Financing Plan, and Monitoring Protocol are subject to CMS approval.

c. Elements of the Mid-Point Assessment must include:

    i. An examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Plans and toward meeting the targets for performance measures as approved in the SUD Monitoring Protocol;

    ii. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;

    iii. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

    iv. For milestones or targets identified by the independent assessor as at medium to high risk of not being met, recommendations for adjustments in the state's SUD Implementation Plan, or to pertinent factors that the State can influence that will support improvement, and

    v. An assessment of whether the state is on track to meet the SUD budget neutrality requirements in these STCs.

76. State Data Collection. The state must collect data and information necessary to oversee service utilization and rate setting by provider/plan, comply with the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP, obtain NCQA and other accreditations that the state may seek, and comply with other existing federal measure sets.

a. The state will use this information in ongoing monitoring of individual wellbeing, provider/plan performance, and continuous quality improvement efforts, in addition to complying with CMS reporting requirements.

b. The state must maintain data dictionary and file layouts of the data collected.

c. The raw and edited data will be made available to CMS within 30 days of a written request.

77. Corrective Action Plan Related to Monitoring. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 81 CMS will withdraw an authority, as described in STC 10, when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

78. Close-Out Report. Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The draft Close-Out Report must comply with the most current guidance from CMS.

b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the

timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 119 and 120 respectively.

c. The state will present to and participate in a discussion with CMS on the Close-Out report.

d. The state must take into consideration CMS' comments for incorporation into the final Close-Out report.

e. The revised Close-Out report is due to CMS no later than 30 calendar days after receipt of CMS's comments.

f. A delay in submitting the draft or final version of the Close-Out report may subject the state to penalties described in STC 72

79. Monitoring Calls. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, including (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, budget neutrality, enrollment and access and progress on the evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
c. The state and CMS will jointly develop the agenda for the calls.

80. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) calendar days prior to the date of the planned public forum, the state must publish the date, time, and location of the forum in a prominent location on its Medicaid website. The state must also post the most recent Annual Monitoring Report on its Medicaid website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the public comments in the Annual Monitoring Report associated with the year in which the forum was held.

XV. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

81. Allowable Expenditures. This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

82. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state and include the reconciling adjustment in the finalization of the grant award to the state.

83. Sources of Non-Federal Share. As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

84. State Certification of Funding Conditions. As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the

demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, consistent with section 1903 of the Act, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

85. Financial Integrity for Managed Care Delivery Systems. As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

86. Requirements for Health Care-Related Taxes and Provider Donations. As a condition provide of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Act, 42 CFR 433.66, and 42 CFR 433.54.

87. State Monitoring of Non-federal Share. If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 72. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state or other entities relating to each locality tax or payments received funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under Section 1903(w) of the Act.

88. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section XVI:

    a. Administrative costs, including those associated with the administration of the demonstration;

    b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

    c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third-party liability.

89. **Program Integrity.** The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

90. **Medicaid Expenditure Groups.** Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table E: Master MEG Chart

MEG	To Which BN Test Does This Apply?	WOW Per Capita	WOW Aggregate	WW	Brief Description

DSHP TANF Children	Main Budget Neutrality Test	X		X	Medical assistance expenditures for Demonstration Population 1: TANF Children less than 21; Expenditure Authority #11 and #13
DSHP TANF Adult	Main Budget Neutrality Test	X		X	Medical assistance expenditures for Demonstration Population 2: TANF Adults aged 21and over; Expenditure Authority 13
DSHP SSI Children	Main Budget Neutrality Test	X		X	Medical assistance expenditures for Demonstration Population 3: Disabled Children less than 21; Expenditure Authority #11 and #12
DSHP SSI Adults	Main Budget Neutrality Test	X		X	Medical assistance expenditures for Demonstration Population 4: Aged and Disabled Adults 21and older; Expenditure Authority #13
DSHP MCHP	Main Budget Neutrality Test	X		X	Medical assistance expenditures for Demonstration Population 5: Infants less than one year of age with income levels above 185 percent FPL through 200 percent FPL.
DSHP Plus State Plan	Main Budget Neutrality Test	X		X	Medical assistance expenditures for Demonstration Population 6: DSHP Plus State Plan.
DSHP Adult Group	Hypo 1	X		X	Medical assistance expenditures for Demonstration Population 11: DSHP Adult Group. Expenditure #13
SUD IMD	Hypo 2	X		X	All expenditures for costs of medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to otherwise eligible

					individuals during a month in an IMD. Expenditure Authority #9.
DSHP Plus HCBS	Hypo 3	X		X	Medical assistance expenditures for Demonstration Population 9: DSHP Plus HCBS. Expenditure Authorities #1, #2, and #3
***DSHP TEFRA-Like Children**	Hypo 3	X		X	Medical assistance expenditures for Demonstration Population 10: DSHP Plus HCBS. Expenditure Authority #4.
Diamond State Health Plan (PROMISE)	Hypo 4	X		X	Medical assistance expenditures for Demonstration Population 10: PROMISE Services. Expenditure Authority #8.
Postpartum Nutrition Support Initiatives	Main Budget Neutrality Test			X	Expenditures to provide the equivalent of up to two meals a day (home-delivered meals and/or food boxes) that do not constitute a full nutritional regimen, up to eighty diapers per week, and up to one pack of baby wipes per week delivered to postpartum beneficiaries, for the first twelve weeks of the postpartum period. Expenditure Authority #15
Contingency Management	Main Budget Neutrality Test			X	Expenditures for evidence based, cost-effective treatment for substance use disorder that combines motivational incentives with behavioral health treatments. Expenditure Authority #16

*DSHP TEFRA-Like

91. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00036/3). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. **Cost Settlements**. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

[Instructions: Consult the RO Financial Lead for assistance in completing this STC and discuss with the state to understand their approach on pharmacy rebates.]

c. **Pharmacy Rebates.** Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget

neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.

d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in section XVI, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in section IX, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

92. Budget Neutrality Specifications Manual. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table F: MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
DSHP TANF Children	Medical assistance expenditures for DSHP TANF Children, as defined in Table A.	Exclude persons identified in Table B. Exclude DSHP FFS Benefits. Exclude SUD IMD spending.	Report on customary lines by category of service.	Date of service	MAP	Y Report months of Medicaid eligibility for DSHP TANF Children, as defined in Table A. Exclude months for persons identified in Table B. Exclude SUD IMD months.	1/1/1994	12/31/2028
DSHP TANF Adult	Medical assistance expenditures for DSHP TANF Adult, as defined in Table A.	Exclude spending for persons identified in Table B. Exclude spending for DSHP FFS Benefits. Exclude SUD IMD spending.	Report on customary lines by category of service.	Date of service	MAP	Y Report months of Medicaid eligibility for DSHP TANF Adult, as defined in Table A. Exclude months for persons identified in Table B. Exclude SUD IMD months.	1/1/1994	12/31/2028
DSHP SSI Children	Medical assistance expenditures for DSHP SSI Children, as defined in Table A.	Exclude spending for persons identified in Table B. Exclude spending for DSHP FFS Benefits.	Report on customary lines by category of service.	Date of service	MAP	Y Report months of Medicaid eligibility for DSHP SSI Children, as defined in Table A. Exclude months for persons identified in	1/1/1994	12/31/2028

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
		Exclude SUD IMD spending.				Table B. Exclude SUD IMD months.		
DSHP SSI Adults	Medical assistance expenditures for DSHP SSI Adults, as defined in Table A.	Exclude spending for persons identified in Table B. Exclude spending for DSHP FFS Benefits. Exclude SUD IMD spending.	Report on customary lines by category of service.	Date of service	MAP	Y Report months of Medicaid eligibility for DSHP SSI Adults, as defined in Table A. Exclude months for persons identified in Table B. Exclude SUD IMD months.	1/1/1994	12/31/2028
DSHP MCHP	Medical assistance expenditures for DSHP MCHP, as defined in Table A, when funded with title XIX	Exclude spending for persons identified in Table B. Exclude spending for DSHP FFS Benefits.	Report on customary lines by category of service.	Date of service	MAP	Y Report months of Medicaid eligibility for DSHP MCHP, as defined in Table A, when funded with title XIX funds. See STC 67(g). Exclude months for persons identified in	7/1/1997	12/31/2028

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
	funds. See STC 67(g).	Exclude SUD IMD spending.				Table B. Exclude SUD IMD months.		
DSHP PLUS State Plan	Medical assistance expenditures for DSHP Plus State Plan, as defined in Table A.	Exclude spending for persons identified in Table B. Exclude spending for DSHP FFS Benefits. Exclude SUD IMD spending.	Report on customary lines by category of service.	Date of service	MAP	Y Report months of Medicaid eligibility for DSHP Plus State Plan, as defined in Table A. Exclude months for persons identified in Table B. Exclude SUD IMD months.	3/22/2012	12/31/2028
DSHP Adult Group	Medical assistance expenditures for DSH Adult Group, as defined in Table A.	Exclude spending for persons identified in Table B. Exclude spending for DSHP FFS Benefits.	Report on customary lines by category of service.	Date of service	MAP	Y Report months of Medicaid eligibility for DSHP Adult Group, as defined in Table A. Exclude months for persons identified in Table B. Exclude SUD IMD months.	1/1/2014	12/31/2028

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
		Exclude SUD IMD spending.						
SUD IMD	SUD IMD spending: Expenditures for otherwise covered services furnished to otherwise eligible individuals provided during a SUD IMD month. See Expenditure Authority #9.	None	Report on customary lines by category of service. Report IMD service expenditures on Line 2A, Mental Health Facility Services - Reg. Payments	Date of service	MAP	Y Report SUD IMD months, which are months of eligibility in which the individual receives treatment for SUD as a short-term resident in an IMD at any point during the month.	7/1/2019	12/31/2028
DSHP PLUS HCBS	Medical assistance expenditures for DSHP Plus HCBS,	Exclude SUD IMD spending.	Report on customary lines by category of service.	Date of service	MAP	Y Report months of Medicaid eligibility for DSHP Plus HCBS, as	3/22/2012	12/31/2028

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
	as defined in Table A. See Expenditure Authorities #1, #2, and #3.					defined in Table A. Exclude SUD IMD months.		
***DSHP TEFRA-Like Children**	Medical assistance expenditures for DSHP TEFRA-Like Children, as defined in Table A. See Expenditure Authority #4.	Exclude SUD IMD spending.	Report on customary lines by category of service.	Date of service	MAP	Y Report months of Medicaid eligibility for DSHP TEFRA-Like Children, as defined in Table A. Exclude SUD IMD months. TEFRA months are calculated by taking 5% of total SSI Children (and reducing the SSI Children months by that amount)	3/22/2012	12/31/2028
Diamond State Health Plan	Expenditures for behavioral health	Exclude SUD IMD spending.	Report PROMISE Services expenditures on	Date of service	MAP	Y Report Medicaid months of eligibility for individuals during	1/1/2015	12/31/2028

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
(PROMISE)	services beyond the services described in the approved state plan for otherwise eligible individuals enrolled in PROMISE. See Expenditure Authority #8.		Line 49, Other Care Services			which they receive PROMISE services at any time in the month. Exclude SUD IMD months.		
Postpartum Nutrition Support Initiatives	See Expenditure Authority # 15	See STC #30	Follow CMS 64.9 Base Category of Service Definitions	Date of service	MAP	N	7/1/2024	12/31/2028
Contingency Management	See Expenditure	See STC #33	Follow CMS 64.9 Base Category of	Date of service	MAP	N	7/1/2024	12/31/2028

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
	Authority # 16		Service Definitions					

*DSHP TEFRA-Like

93. Demonstration Years. Demonstration Years (DY) for this demonstration are defined in the table below.

Table G: Demonstration Years

Demonstration Year 30	July 1, 2024 to December 31, 2024	6 months
Demonstration Year 31	January 1, 2025 to December 31, 2025	12 months
Demonstration Year 32	January 1, 2026 to December 31, 2026	12 months
Demonstration Year 33	January 1, 2027to December 31, 2027	12 months
Demonstration Year 34	January 1, 2028 to December 31, 2028	12 months

*For the purpose of calculating budget neutrality for the temporary extension period of January 1, 2024 through June 30, 2024, DY 29 budget neutrality limits will apply.

94. Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing demonstration's actual expenditures to the budget neutrality expenditure limits described in section XI. CMS will provide technical assistance, upon request.[7]

[7] 42 CFR 431.420(a)(2) provides that states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

95. Claiming Period. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

96. Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

97. Budget Neutrality Mid-Course Adjustment Request. No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new

expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process.** In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 7 (c). If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care

b. **Types of Allowable Changes.** Adjustments will only be made for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments CMS may consider allowable include the following:

    i. Provider rate increases that are anticipated to further strengthen access to care;

    ii. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly, or unintended omission of certain applicable costs of services for individual MEGs;

    iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

    iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

    v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

vi. High-cost innovative medical treatments that states are required to cover; or,

vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration covered service or population and that is likely to further strengthen access to care.

XVI. MONITORING BUDGET NEUTRALITY

98. Limit on Title XIX Funding. The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit may consist of a Main Budget Neutrality Test and a Hypothetical Budget Neutrality Tests if applicable, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

99. Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table E, Master MEG Chart and Table F, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment

in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

100. Calculation of the Budget Neutrality Limits and How They Are Applied. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

101. Main Budget Neutrality Test. The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of the limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test the Composite Federal Share for this test is calculated based on all MEGs indicated as "Both."

Table H: Main Budget Neutrality Test

MEG	PC or Agg*	WOW Only, WW Only, or Both	BASE YEAR *[define]*	TREND	DY 30	DY 31	DY 32	DY 33	DY 34
DSHP TANF Children	PC	Both	$	4.50%	$457.45	$517.99	$541.30	$565.66	$591.11
DSHP TANF Adult	PC	Both	$	4.80%	$827.81	$857.44	$898.60	$941.73	$986.93
DSHP SSI Children	PC	Both	$	4.90%	$2,976.20	$3,122.29	$3,275.28	$3,435.77	$3,604.12
DSHP SSI Adults	PC	Both	$	4.70%	$2,677.33	$2,771.16	$2,901.40	$3,037.77	$3,180.55
DSHP MCHP	PC	Both		4.50%	$457.45	$517.99	$541.30	$565.66	$591.11
DSHP PLUS State Plan	PC	Both		4.90%	$2,037.78	$2,112.22	$2,215.72	$2,324.29	$2,438.18
Contingency Management	Agg	WW only		N/A	The state must have savings to offset these expenditures.				
Postpartum Nutrition Initiative	Agg	WW Only		N/A	The state must have savings to offset these expenditures.				

*PC = Per Capita, Agg = Aggregate

102. Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for

hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

103. Hypothetical Budget Neutrality Test 1: DSHP Adult Group. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table I: Hypothetical Budget Neutrality Test 1

MEG	PC or Agg*	WOW Only, WW Only, or Both	BASE YEAR	TREND	DY 30	DY 31	DY 32	DY 33	DY 34
DSHP Adult Group	PC	Both	$1,064.62 DY 28 Actual PMPM Cost	4.60%	$1,126.19	$1,164.82	$1,218.40	$1,274.45	$1,333.07

104. Hypothetical Budget Neutrality Test 2: SUD Initiative. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 2. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are

indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table J: Hypothetical Budget Neutrality Test 2

MEG	PC or Agg*	WOW Only, WW Only, or Both	BASE YEAR	TREND	DY 30	DY 31	DY 32	DY 33	DY 34
SUD IMD	PC	Both		4.80%	$1,057.05	$1,107.79	$1,160.96	$1,216.69	$1,275.09

105. Hypothetical Budget Neutrality Test 3: DSHP Plus HCBS and DSHP TEFRA-Like Children. DSHP Plus HCBS and DSHP TEFRA-Like Children are "pass-through" or "hypothetical" population, and are included in this demonstration, and in the budget neutrality. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 3. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table K: Hypothetical Budget Neutrality Test 3

MEG	PC or Agg*	WOW Only, WW Only, or Both	BASE YEAR	TREND	DY 30	DY 31	DY 32	DY 33	DY 34
DSHP Plus HCBS	PC	Both	$6,925.33 DY28	4.70%	$7,334.56	$7,591.61	$7,948.42	$8,322.00	$8,713.13

DSHP TEFRA-Like Children	PC	Both	$2,795.66 DY28	4.90%	$2,967.93	$3,076.35	$3,227.09	$3,385.22	$3,551.10

*DSHP TEFRA-Like

106. Hypothetical Budget Neutrality Test 4: PROMISE is "pass-through" or "hypothetical" expenditure category, and is included in this demonstration, and in the budget neutrality. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 4. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table L: Hypothetical Budget Neutrality Test 4

MEG	PC or Agg*	WOW Only, WW Only, or Both	BASE YEAR	TREND	DY 30	DY 31	DY 32	DY 33	DY 34
Diamond State Health Plan (PROMISE)	PC	Both	$544.35 DY 28	4.80%	$577.20	$597.86	$626.56	$656.63	$688.15

107. Composite Federal Share. The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

108. Exceeding Budget Neutrality. CMS will enforce the budget neutrality agreement over the demonstration period, which extends from January 1, 2024 to December 31, 2028. If at the end of the demonstration approval period the Main Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

Table M: Savings Phase-Down					
MEG	**DY 30**	**DY 31**	**DY 32**	**DY 33**	**DY 34**
DSHP TANF Children	25%	25%	25%	25%	25%
DSHP TANF Adult	25%	25%	25%	25%	25%
DSHP SSI Children	25%	25%	25%	25%	25%
DSHP SSI Adults	25%	25%	25%	25%	25%
DSHP MCHP	25%	25%	25%	25%	25%
DSHP PLUS State Plan	80%	70%	60%	50%	40%

109. Corrective Action Plan. If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table N: Budget Neutrality Test Mid-Course Correction Calculation		
Year	**Cumulative Target Definition**	**Percentage**
DY 29	Cumulative budget neutrality limit plus:	2.0 percent
DY 30 & 31	Cumulative budget neutrality limit plus:	1.5 percent
DY 31 through 32	Cumulative budget neutrality limit plus:	1.0 percent
DY 32 through 33	Cumulative budget neutrality limit plus:	0.5 percent
DY 33 through 34	Cumulative budget neutrality limit plus:	0 percent

XVII. EVALUATION OF THE DEMONSTRATION

110. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents, and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce, or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. This may also include the state's participation – including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable – in a federal learning collaborative aimed at cross-state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and evaluation. The state may

claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 72.

111. Independent Evaluator. The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

112. Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be drafted in accordance with:

a. Attachment A (Developing the Evaluation Design) of these STCs,

b. CMS's evaluation design guidance for SUD, including guidance about SUD and overall demonstration sustainability, and

c. Any applicable CMS evaluation guidance and technical assistance for the demonstration's other policy components.

The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined culturally appropriate for the communities impacted by the demonstration, the state is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic), as these implementation strategies help create strong comparison groups and facilitate robust evaluation. The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 119 and 120.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design or submit a new Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amendment Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

113. Evaluation Budget. A budget for the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

115. Evaluation Design Approval and Updates. The state must submit a revised draft Evaluation Design within sixty (60) calendar days after receipt of CMS' comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) calendar days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation progress in each of the Quarterly and Annual Monitoring Reports. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in Monitoring Reports.

116. Evaluation Questions and Hypotheses. Consistent with Attachments F and G (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and also its effectiveness in achieving the goals. For example, hypotheses for the SUD component of the demonstration must support an assessment of the demonstration's success in achieving the core goals of the program through addressing, among other outcomes,

initiation and compliance with treatment, utilization of health services in appropriate care settings, and reductions in key outcomes such as deaths due to overdose. The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as likelihood of enrollment and enrollment continuity, and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures should be selected from nationally recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP; Consumer Assessment of Health Care Providers and Systems (CAHPS); the Behavioral Risk Factor Surveillance System (BRFSS) survey; and/or measures endorsed by National Quality Forum (NQF).

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and experience with the various demonstration policy components, including but not limited to the continuous eligibility and coverage, and beneficiary experiences with access to and quality of care. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration components in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—or barriers to—successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

a. Hypotheses for the SUD program must include an assessment of the objectives of the SUD component of this section 1115 demonstration. Examples include (but are not limited to): initiation and engagement with treatment, utilization of health services (emergency department and inpatient hospital settings), and a reduction in key outcomes, such as deaths due to overdose.

b. Hypotheses for the contingency management program must align with the goals of the SUD program. They should aim to increase rates of identification, initiation, and engagement in treatment; increase adherence to and retention in treatment; reduce overdose deaths; reduce utilization of emergency departments and inpatient hospital settings for treatment where preventable or medically inappropriate; reduce readmissions where preventable or medically inappropriate; and improve access to care for physical health outcomes among beneficiaries.

c. The state must develop hypotheses and research questions to evaluate the effectiveness of covering the home visits for pregnant women and children on their quality of care, health outcomes, as well as in mitigating disparities in those outcomes. Likewise, the evaluation is required to assess whether covering the second home-delivered meal for HCBS beneficiaries in DSHP Plus and the services/benefits under the Nursing Home Transition Program help facilitate the independence and transition to HCBS settings of the populations of focus. The evaluation also must analyze the usefulness of the pediatric respite benefit and the self-directed option for children receiving state plan personal care services, including their effects in improving care coordination and family well-being.

d. The state must develop hypotheses and research questions to evaluate the effectiveness of Delaware's Food Box and Diaper Initiative for postpartum beneficiaries. Specifically, an evaluation is expected to include an assessment of the effects of the initiative on infant utilization of appropriate care (for example, preventative and routine care as opposed to emergency and impatient care), maternal mental health outcomes, and household experience with the initiative on financial and overall wellbeing.

As part of its evaluation efforts, the state must also conduct a demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation, Medicaid health services expenditures, and provider uncompensated care costs, if applicable. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

Finally, the state must accommodate data collection and analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes and help inform how the demonstration's various policies might support reducing such disparities.

117. Interim Evaluation Reports. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report must be posted to the state's website with the application for public comment.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved evaluation design.

b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, and depending on the timeline of expiration/phase-out, the Interim Evaluation Report must include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted, or one year prior to the end of the demonstration, whichever comes sooner. If the state made changes to the demonstration in its application for extension, the research questions and hypotheses and a description of how the design was adapted should be included. If the state is not requesting an extension for a demonstration, an Interim Evaluation report is due one year prior to the end of the demonstration. For demonstration phase-outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit the revised Interim Evaluation Report sixty (60) calendar days after receiving CMS's comments on the draft Interim Evaluation Report, if any.

e. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within thirty (30) calendar days.

f. The Interim Evaluation Report must comply with Attachment G (Preparing the Interim and Summative Evaluation Report) of these STCs.

118. Summative Evaluation Report. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period, within eighteen (18) months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment G (Preparing the Interim and Summative Evaluation Reports) of these STCs, and in alignment with the Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state shall submit the revised Summative Evaluation Report within sixty (60) calendar days of receiving comments from CMS on the draft, if any.
b. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within thirty (30) calendar days.

119. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These

discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

a. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation, and/or the Summative Evaluation Report.

b. **Public Access.** In accordance with 42 CFR 431.424, the state shall post the final documents (e.g., Implementation Plan, Monitoring Protocol, Monitoring Reports, Mid-Point Assessment, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within thirty (30) calendar days of approval by CMS.

c. **Additional Publications and Presentations.** For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given thirty (30) calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

XVIII. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

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

Date - Specific	Deliverable	STC Reference

Within 120 days of expiration	Submit a Draft Close-Out Report	STC 78
Within 30 days of receipt of CMS comments	Submit Final Close-Out Report	STC 78 (d)
30 days after approval date	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
No later than150 days after SUD approval date	SUD Monitoring Protocol Revised no later than 60 days following receipt of CMS comments.	STC 73
No later than 180 days after approval date	Evaluation Design Revised no later than 60 days after receipt of CMS comments.	STC 115
No later than 30 days after CMS Approval	Approved Evaluation Design published to state's Medicaid website	STC 115
90 days after DY30 January 1, 2025	SUD Mid-Point Assessment Revised no later than 60 days following receipt of CMS comments.	STC 75
One year prior to the end of the demonstration, or with renewal application	Interim Evaluation Report\ Revised no later than 60 days after receipt of comments.	STC 117 (c)
No later than 18 months after the end of the demonstration	Summative Evaluation Report Revised no later than 60 days after receipt of CMS comments.	STC 118
No later than 30 calendar days after CMS approval	Approved Final Summative Evaluation Report published to state's website	STC 118(b)

Table XX. Schedule of Annual/Quarterly Deliverables

	Deliverable	STC Reference

Annually	By April 1st - Draft Annual Report	Section XIII, STC 78
	Monitoring Reports	
Quarterly (05/31, 08/31, 11/30)	Quarterly Operational Reports	Section XIII, STC 78
	Quarterly Enrollment Reports	Section XIII, STC 78
	CMS-64 Reports	Section XV, STC 95
	Eligible Member Months	Section XV STC 95(e)

ATTACHMENT A

Quarterly Report Content and Format

Under Section XIII, STC 55, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

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

NARRATIVE REPORT FORMAT:

Title Line One – Diamond State Health Plan

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: 12 (1/1/2007 – 12/31/2007)
Federal Fiscal Quarter: 1/2007 (1/07 - 3/07)

Introduction

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

Enrollment Information

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

Enrollment Counts

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

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

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Quarterly Report Content and Format

Demonstration Populations (as hard coded in the CMS 64)	**Current Enrollees** (to date)	**Disenrolled in Current Quarter**
Population 8: DSHP Plus State Plan		
Population 9: DSHP Plus HCBS		
Population 10: DSHP TEFRA-Like		
Population 11: DSHP Adult Group		
Population 12: PROMISE		
Population 13: Former Foster Care Youth		

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

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

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

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

Member Month Reporting
Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Eligibility Group	**Month 1**	**Month 2**	**Month 3**	**Total for Quarter Ending XX/XX**
DSHP TANF Children				
DSHP TANF Adult				
DSHP SSI Children				

DSHP SSI Adults				
DSHP MCHP (Title XIX match)*				
DSHP Plus State Plan				
DSHP Adult				
SUD IMD				
DSHP Plus HCBS				
DSHP TEFRA-Like				
DSHP PROMISE				
* This EG does not include children funded through title XXI. Please note within the report, if the state must use title XIX funds for other uninsured children meeting the definition specified in section 2110(b)(1) of the Social Security Act if the state exhausts title XXI funds.				

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

B. For Informational Purposes Only

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

ATTACHMENT A

Quarterly Report Content and Format

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

Quality Assurance/Monitoring Activity
Identify any quality assurance/monitoring activity in current quarter. As part of the annual report, the state must also report on the effectiveness of the updated comprehensive Quality Strategy as it impacts the demonstration.

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

Demonstration Evaluation
Discuss progress of evaluation design and planning.

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

State Contact(s)
Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

ATTACHMENT B

Historical Budget Neutrality Data

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

In 2012, the DSHP PLUS (known as PLUS) MEG was added to the state plan budget neutrality agreement. This MEG was included for DY 17 and DY 18 (CY 2012 and CY 2013). As part of the DY 19 – DY 23 renewal, the PLUS MEG was split into DSHP PLUS State Plan and DSHP PLUS HCBS. The PLUS HCBS MEG became a waiver population for purposes of budget neutrality for DY 19 – DY 23 (CY 2014 –CY 2018). In the DY 24 – DY 28, the PLUS HCBS MEG became a hypothetical MEG.

Several hypothetical MEGs have been added to the demonstration. These state may not earn budget neutrality savings on these populations, however, the State is at risk for the cost of services provided to these populations. A separate table is included to identify these MEGS and their related PMPMs.

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

			TANF Children		**TANF Adults**		**SSI Children**		**SSI Adults**	
DY	Time Period	Service Category	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM
1	FFY 1996	*Pharmacy*	25.3%	$ 9.66	32%	$ 29.08	21%	$ 51.51	27.4%	$ 58.95
		Behavioral Health	29.8%	$ 31.64	29.8%	$ 1.15	29.8%	$ 85.17	29.8%	$ 119.28
		Managed Care	6.79%	$ 92.60	6.17%	$ 215.39	6.85%	$ 647.08	6.85%	$ 523.85
2	FFY 1997	*Pharmacy*	6.79%	$ 10.31	6.17%	$ 30.87	6.85%	$ 55.04	6.85%	$ 169.84
		Behavioral Health	6.79%	$ 33.79	6.17%	$ 1.22	6.85%	$ 85.17	6.85%	$ 119.28
		Managed Care	6.79%	$ 98.89	6.17%	$ 228.67	6.85%	$ 691.41	6.85%	$ 559.74
3	FFY 1998	*Pharmacy*	6.79%	$ 11.01	6.17%	$ 32.78	6.85%	$ 58.81	6.85%	$ 181.47
		Behavioral Health	6.79%	$ 36.08	6.17%	$ 1.29	6.85%	$ 97.23	6.85%	$ 136.19
		Managed Care	6.79%	$ 105.60	6.17%	$ 242.78	6.85%	$ 738.77	6.85%	$ 598.08

ATTACHMENT B

Historical Budget Neutrality Data

4	FFY 1999	*Pharmacy*	6.79%	$ 11.76	6.17%	$ 34.80	6.85%	$ 62.83	6.85%	$ 193.90
		Behavioral Health	6.79%	$ 38.53	6.17%	$ 1.37	6.85%	$ 103.89	6.85%	$ 145.51
		Managed Care	6.79%	$ 112.77	6.17%	$ 257.76	6.85%	$ 789.37	6.85%	$ 639.05
5	FFY 2000	*Pharmacy*	6.79%	$ 12.56	6.17%	$ 36.95	6.85%	$ 67.14	6.85%	$ 207.18
		Behavioral Health	6.79%	$ 41.15	6.17%	$ 1.46	6.85%	$ 111.01	6.85%	$ 155.48
		Managed Care	6.79%	$ 120.43	6.17%	$ 273.67	6.85%	$ 843.45	6.85%	$ 682.82
6	FFY 2001	*Pharmacy*	6.79%	$ 13.41	6.17%	$ 39.23	6.85%	$ 71.74	6.85%	$ 221.37
		Behavioral Health	6.79%	$ 43.94	6.17%	$ 1.55	6.85%	$ 118.62	6.85%	$ 166.13
		Managed Care	6.79%	$ 128.61	6.17%	$ 290.55	6.85%	$ 901.22	6.85%	$ 729.59
7	FFY 2002	*Pharmacy*	6.79%	$ 14.32	6.17%	$ 41.65	6.85%	$ 76.65	6.85%	$ 236.54
		Behavioral Health	6.79%	$ 46.93	6.17%	$ 1.64	6.85%	$ 126.74	6.85%	$ 177.51
		Managed Care	6.79%	$ 137.34	6.17%	$ 308.48	6.85%	$ 962.95	6.85%	$ 779.57
8	FFY 2003	*Pharmacy*	6.79%	$ 15.29	6.17%	$ 44.22	6.85%	$ 81.90	6.85%	$ 236.54
		Behavioral Health	6.79%	$ 50.11	6.17%	$ 1.74	6.85%	$ 135.42	6.85%	$ 189.67
		Managed Care	6.79%	$ 146.67	6.17%	$ 327.51	6.85%	$ 1,028.92	6.85%	$ 832.97
	Oct – Dec. 2003	*Pharmacy*	6.79%	$ 15.54	6.17%	$ 44.89	6.85%	$ 83.27	6.85%	$ 256.96
		Behavioral Health	6.79%	$ 50.94	6.17%	$ 1.77	6.85%	$ 137.68	6.85%	$ 192.84
		Managed Care	6.79%	$ 149.10	6.17%	$ 332.45	6.85%	$ 1,046.10	6.85%	$ 846.88

ATTACHMENT B

Historical Budget Neutrality Data

			TANF Children		TANF Adults		SSI Children		SSI Adults		DSHP Plus	
DY	Time Period	Service Category	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend rate	PMPM
9	CY 2004	*Pharmacy*	6.79%	$ 16.60	6.17%	$ 47.66	6.85%	$ 88.97	6.85%	$ 74.56		
		Behavioral Health	6.79%	$ 54.40	6.17%	$ 1.88	6.85%	$ 147.11	6.85%	$ 206.05		
		Managed Care	6.79%	$ 159.22	6.17%	$ 352.96	6.85%	$ 1,117.76	6.85%	$ 904.89		
10	CY 2005	*Pharmacy*	6.79%	$ 17.73	6.17%	$ 50.60	6.85%	$ 95.07	6.85%	$ 93.37		
		Behavioral Health	6.79%	$ 58.09	6.17%	$ 1.99	6.85%	$ 157.19	6.85%	$ 220.16		
		Managed Care	6.79%	$ 170.03	6.17%	$ 374.74	6.85%	$ 1,194.33	6.85%	$ 966.88		
11	CY 2006	*Pharmacy*	6.79%	$ 18.93	6.17%	$ 53.72	6.85%	$ 101.58	6.85%	$ 13.47		
		Behavioral Health	6.79%	$ 62.04	6.17%	$ 2.11	6.85%	$ 167.96	6.85%	$ 235.25		
		Managed Care	6.79%	$ 181.58	6.17%	$ 397.86	6.85%	$ 1,276.14	6.85%	$ 1,033.11		
12	CY 2007		6.79%	$ 280.38	6.17%	$ 481.68	6.85%	$ 1,651.56	6.85%	$ 1,690.19		
13	CY 2008		5.84%	$ 296.75	5.16%	$ 506.54	5.42%	$ 1,741.07	5.42%	$ 1,781.79		
14	CY 2009		5.84%	$ 314.08	5.16%	$ 532.54	5.42%	$ 1,835.44	5.42%	$ 1,878.37		
15	CY 2010		5.84%	$332.40	5.16%	$560.21	5.20%	$1,930.89	5.20%	$1,976.02		
16	CY 2011		5.84%	$351.81	5.16%	$589.12	5.20%	$2,031.30	5.20%	$2,078.77		
17	CY 2012		5.84%	$372.36	5.16%	$619.52	5.20%	$2,136.93	5.20%	$2,186.87	2.76%	$2,394.17

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Historical Budget Neutrality Data

18	CY 2013	[redacted]	5.84%	$394.11	5.16%	$651.49	5.20%	$2,248.05	5.20%	$2,300.59	2.76%	$2,460.24
19	CY 2014		5.00%	$413.82	5.16%	$685.11	5.00%	$2,360.45	4.50%	$2,404.12	2.76%	$2,528.14
20	CY 2015		5.00%	$434.51	5.16%	$720.46	5.00%	$2,478.47	4.50%	$2,512.31	2.76%	$2,597.92
21	CY 2016		5.00%	$456.24	5.16%	$757.64	5.00%	$2,602.40	4.50%	$2,625.36	2.76%	$2,669.62
22	CY 2017		5.00%	$479.05	5.16%	$796.73	5.00%	$2,732.52	4.50%	$2,743.50	2.76%	$2,743.30
23	CY 2018		5.00%	$503.00	5.16%	$837.84	5.00%	$2,869.14	4.50%	$2,866.96	2.76%	$2,819.02

Expansion populations were added in 2010 to reflect the treatment of Expansion Adults and FP Expansion populations as allowed under ACA. Prior to April 1, 2010, Expansion Adults were treated as a waiver population. TEFRA Kids were added with the DY 19 extension as were PROMISE services though PROMISE was not implemented until DY 20.

		[redacted]	**Expansion adults**		**FP Expansion**		**TEFRA Kids**		**PROMISE**	
DY	Time period		Trend rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM
15	CY 2010		5.02%	$763.70	3.83%	$6.89				
16	CY 2011		5.02%	$802.05	3.83%	$7.15				
17	CY 2012		5.02%	$842.33	3.83%	$7.47				

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Historical Budget Neutrality Data

18	CY 2013	[redacted]	5.02%	$884.63	6.10%	$7.93	[redacted]			
19	CY 2014	[redacted]	5.10%	$463.14	[redacted]		5.00%	$2360.45	[redacted]	
20	CY 2015	[redacted]	5.10%	$486.76	[redacted]		5.00%	$2478.47	5.10%	$1233.54
21	CY 2016	[redacted]	5.10%	$511.58	[redacted]		5.00%	$2602.40	5.10%	$1296.54
22	CY 2017	[redacted]	5.10%	$537.68	[redacted]		5.00%	$2732.52	5.10%	$1362.57
23	CY 2018	[redacted]	5.10%	$565.10	[redacted]		5.00%	$2869.14	5.10%	$1432.06

ATTACHMENT C

DSHP Plus HCBS Service Definitions

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

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DSHP Plus HCBS Service Definitions

HCBS Service	Service Definition
	be coordinated with the assisted living provider. Personal care services are provided in assisted living facilities as part of the community-based residential service. To avoid duplication, personal care (as a separate service) is not available to persons residing in assisted living facilities.
Personal Care/ Attendant Care Services	Personal care includes assistance with ADLs (e.g. bathing, dressing, personal hygiene, transferring, toileting, skin care, eating and assisting with mobility). When specified in the service plan, this service includes assistance with instrumental activities of daily living (IADLs) (e.g. light housekeeping chores, shopping, meal preparation). Assistance with IADLs must be essential to the health and welfare of the participant based on the assessment of the Case Manager and with input from the participant and their family caregivers. This service is not available to persons residing in Assisted Living.
Respite Care	Respite care includes services provided to participants unable to care for themselves furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. FFP is not claimed for the cost of room and board. This is provided both at home and in Nursing and Assisted Living Facilities. This service is limited to no more than fourteen (14) days per year. The managed care organization may authorize service request exceptions above these limits on a case-by-case basis when it determines that: • No other service options are available to the member, including services provided through an informal support network; • The absence of the service would present a significant health and welfare risk to the member; and • Respite service provided in a nursing home or assisted living facility is not utilized to replace or relocate an individual's primary residence.
Adult Day Services	Services furnished in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech

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DSHP Plus HCBS Service Definitions

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

HCBS Service	Service Definition
	available to persons residing in Assisted Living and Nursing Facilities. Cognitive services are limited to twenty (20) visits per year plus an assessment. The managed care organization may authorize service request exceptions above this limit. Cognitive Services include two key components: • Multidisciplinary Assessment and consultation to determine the participant's level of functioning and service needs. This Cognitive Services component includes neuropsychological consultation and assessments, functional assessment and the development and implementation of a structured behavioral intervention plan. • Behavioral Therapies include remediation, programming, counseling and therapeutic services for participants and their families which have the goal of decreasing or modifying the participant's significant maladaptive behaviors or cognitive disorders that are not covered under the Medicaid State Plan. These services consist of the following elements: Individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under state law.), services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness, individual activity therapies that are not primarily recreational or diversionary, family counseling (the primary purpose of which treatment of the individual's condition) and diagnostic services.
Personal Emergency Response System	A Personal Emergency Response System (PERS) is an electronic device that enables a waiver participant to secure help in an emergency. As part of the PERS service, a participant may be provided with a portable help button to allow for mobility. The PERS device is connected to the participant's phone and programmed to signal a response center and/or other forms of assistance once the help button is activated. This service is not available to persons residing in Assisted Living.

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DSHP Plus HCBS Service Definitions

HCBS Service	Service Definition
Support for Participant Direction	DSHP Plus members may opt to self-direct their Personal Care/Attendant services. Support for Participant Direction combines two functions: financial management services (FMS) and information and assistance in support of participant direction (support brokerage). Providers of Support for Participant Direction carry out activities associated with both components. The Support for Participant Direction service provides assistance to participants who elect to self-direct their personal care services. Participant direction affords DSHP Plus members the opportunity to have choice and control over how personal care services are provided and who provides the services. Member participation in participant direction is voluntary. Members may participate in or withdraw from participant direction at any time. To the extent possible, the member shall provide his/her personal care provider ten (10) days advance notice regarding his/her intent to withdraw from participant direction. Providers of this service perform various functions to support participants in planning for and carrying out their responsibilities as common-law employers of personal care attendants. (A) **Financial Management Services.** Financial management services provide assistance to members with managing funds associated with the services elected for self-direction. The following supports are provided • Assist participants in verifying personal care attendant's citizen status • Collect and process personal care attendants' timesheets • Process payroll, withholding, filing and payment of applicable federal, state, and local employment-related taxes and insurance • Execute and hold Medicaid provider agreements • Receive and disperse funds for the payment of services to personal care attendants (B) **Support Brokerage.** Support Brokerage service offers the

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DSHP Plus HCBS Service Definitions

HCBS Service	Service Definition
	following support: • Coordinate with participants to develop, sign, and update individual service plans • Recruit personal care attendants • Maintain a roster of personal care attendants • Secure background checks on prospective personal care attendants on behalf of participants • Provide information on employer/employee relations • Provide training to participants and personal care attendants • Provide assistance with problem resolution • Maintain participant files • Provide support in arranging for emergency back-up care
Independent Activities of Daily Living (Chore) Services	Chore services constitute housekeeping services that include assistance with shopping, meal preparation, light housekeeping, and laundry. This is an in-home service for frail older persons or adults with physical disabilities. The service assists them to live in their own homes as long as possible. The service must be provided by trained housekeepers. This service is not available to persons residing in Assisted Living.
Nutritional Supports	Nutritional supports for individuals diagnosed with AIDS that are not covered under the state plan. This service is for individuals diagnosed with HRD/AIDS to ensure proper treatment in those experiencing weight loss, wasting, malabsorption and malnutrition. Such oral nutritional supplements are offered as a service to those identified at nutritional risk. This service covers supplements not otherwise covered under the state plan service. This service does not duplicate a service provided under the state plan as an EPSDT service. Prior authorized by CM. Service must be prior authorized by case manager in conjunction with the consultation of a medical professional's recommendation for service. Standard for assessing the nutritional risk factors: • Weighing less than 90% of usual body weight; • Experiencing weight loss over a one to six month period;

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DSHP Plus HCBS Service Definitions

HCBS Service	Service Definition
	• Losing more than five pounds within a preceding month; • Serum albumin is less than 3.2 or very high indicating dehydration, difficulty swallowing or chewing, or persistent diarrhea; or • Wasting syndrome affected by a number of factors including intake, nutrient malabsorption & physiological and metabolic changes.
Specialized Medical Equipment and Supplies	Specialized medical equipment and supplies not covered under the Medicaid State Plan. This service includes: (a) devices, controls, or appliances specified in the plan of care that enable the member to increase his/her ability to perform activities of daily living; (b) devices, controls, or appliances that enable the member to perceive, control, or communicate with the environment in which he/she lives; (c) items to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the state plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the state plan. Items reimbursed under DSHP Plus are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the member. This service does not duplicate a service provided under the state plan as an EPSDT service.
Minor Home Modifications	Minor home modifications are funded up to $6,000 per project; $10,000 per benefit year; and $20,000 per lifetime. The contractor case manager may authorize service request exceptions above this limit when it determines the expense is cost-effective. This service is not available to persons residing in Assisted Living. Provision and installation of certain home mobility aids (e.g., a wheelchair ramp and modifications directly related to and specifically required for the construction or installation of the ramp, hand rails for interior or exterior stairs or steps, grab bars and other devices) and minor physical adaptations to the interior of a member's place of residence which are necessary to ensure the health, welfare

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DSHP Plus HCBS Service Definitions

HCBS Service	Service Definition
	and safety of the individual, or which increase the member's mobility and accessibility within the residence, such as widening of doorways or modification of bathroom facilities. Excluded are installation of stairway lifts or elevators and those adaptations which are considered to be general maintenance of the residence or which are considered improvements to the residence or which are of general utility and not of direct medical or remedial benefit to the individual, such as installation, repair, replacement or roof, ceiling, walls, or carpet or other flooring; installation, repair, or replacement of heating or cooling units or systems; installation or purchase of air or water purifiers or humidifiers; and installation or repair of driveways, sidewalks, fences, decks, and patios. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.
Home Delivered Meals	Home-delivered meals (up to 2 meals per day). Nutritionally well-balanced meals, other than those provided under Title III C-2 of the Older Americans Act or through SSGB funds, that provide at least one-third but no more than two-thirds of the current daily Recommended Dietary Allowance (as estimated by the Food and Nutrition Board of Sciences – National Research Council) and that will be served in the enrollee's home. Special diets shall be provided in accordance with the individual Plan of Care when ordered by the enrollee's physician. These meals are delivered to the participant's community residence and not to other setting, such as Adult Day Programs or Senior Centers. The contractor must coordinate the delivery of these meals with staff within the Division of Services for Aging & Adults with Physical Disabilities (DSAAPD) that authorize home-bound meals utilizing Title III (Older Americans Act) and Social Service Block Grant (SSBG) funds.
DSHP Plus Nursing Facility Transition Services (formerly Money	The state will provide coverage of up to $2500 in short-term nursing facility transition services to support a DSHP Plus member's transition from a nursing facility to an HCBS setting:

HCBS Service	Service Definition
Follows the Person Demonstration Grant services)	a. Payment for securing a community-based home: DSHP Plus members may receive services for non-recurring costs associated with securing a community-based home. These costs may include apartment application and administrative fees, as well as, HCBS goods and services including but not limited home furnishings essential for the transition. b. Payment for activities while prior to transitioning from a nursing facility: DSHP Plus members may receive services and activities such as one-time home accessibility modifications required for a healthy, safe and sustainable transition, community transition services (as defined by CMS for 1915(c) waivers), and case management prior to an individual transitioning from a nursing facility setting. 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 include: (1) security deposits that are required to obtain a lease on an apartment or home; (2) 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; (3) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (4) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;

HCBS Service	Service Definition
	(5) moving expenses; (6) necessary home accessibility adaptations; and (7) activities to assess need, arrange for and procure need resources. c. The MCO case manager may authorize service request exceptions above the $2500 limit. Exceptions must be specific to an individual's need and be documented in the person-centered service plan.

ATTACHMENT D

PROMISE Eligibility Criteria and Service Definitions

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

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

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

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

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

Targeting Criteria

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

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PROMISE Eligibility Criteria and Service Definitions

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[8]
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
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[9]
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)* [10]	Mood Disorders
296.40	296.40	Bipolar I Disorder, Most Recent Episode Hypomanic [11]	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)* [12]	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

[8] In DSM 5, the associated diagnostic category is labeled, "Schizophrenia Spectrum and Other Psychotic Disorders".
[9] In DSM 5, mood disorders are broken out into "Depressive Disorders" and "Bipolar and Related Disorders".
[10] The DSM 5 code for Major Depressive Disorder, Recurrent, with Psychotic Features is 296.34.
[11] In DSM 5 code 296.40 is also used for "Bipolar I Disorder, Current or Most Recent Episode Manic, Unspecified".
[12] The DSM 5 code for "Bipolar I Disorder, Current or Most Recent Episode Manic, with Psychotic Features" is 296.44.

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PROMISE Eligibility Criteria and Service Definitions

DSAMH Current SPMI Diagnosis Codes (updated 7/1/2012)			
DSM IV Code	**DSM 5 Code**	**Disorder**	**DSM IV Category**
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)*[13]	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
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[14]

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:

[13] The DSM 5 code for "Bipolar I Disorder, Current or Most Recent Episode Depressed, with Psychotic Features" is 296.54.
[14] In DSM 5, PTSD is moved to another diagnostic category, called "Trauma- and Stressor-Related 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.

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[15]:

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)

[15] 2nd edition ASAM by Dr. David Mee-Lee et al. at http://www.asam.org/publications/patient-placement-criteria/ppc-2r.

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PROMISE Eligibility Criteria and Service Definitions

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 in the below).

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

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PROMISE Eligibility Criteria and Service Definitions

PROMISE 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. 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. In the performance of providing information to beneficiaries, the care manager will: • Inform beneficiaries about the HCBS, required needs assessments, the person-centered planning process, service alternatives, service delivery options (opportunities for beneficiary-direction), roles, rights, risks, and responsibilities. • Inform beneficiaries on fair hearing rights and assist with fair hearing requests when needed and upon request. In the performance of facilitating access to needed services and supports, the care manager will: • Collect additional necessary information including, at a minimum, beneficiary preferences, strengths, and goals to inform the development of the beneficiary-centered Recovery Plan. • Assist the beneficiary and his/her service planning team in identifying and choosing willing and qualified providers. • Coordinate efforts and prompt the beneficiary to ensure the completion of activities necessary to maintain HCBS program eligibility. In the performance of the coordinating function, the care manager will: • Coordinate efforts in accordance with department requirements and prompt the beneficiary to participate in the completion of a needs assessment as required by the State to identify appropriate levels of need and to serve as the foundation for the development of and updates to the Recovery Plan. • Use a person-centered planning approach and a team process which may include peer care managers to develop the beneficiary's Recovery Plan to meet the beneficiary's needs in the least restrictive manner possible. At a minimum, the approach shall: o 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. o 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. o Be timely and occur at times and locations of convenience to the beneficiary; reflect cultural considerations of the beneficiary. o Include strategies for solving conflict or disagreement within the process. o Offer choices to the beneficiary regarding the services and supports they receive and the providers who may render them. o Inform beneficiaries of the method to request updates to the Recovery Plan.

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

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PROMISE Eligibility Criteria and Service Definitions

PROMISE Service	Service Definition
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. **Definitions:** The services are defined as follows: • CPST are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the beneficiary's Recovery Plan. CPST is a face-to-face intervention with the beneficiary present; however, family or other collaterals may also be involved. This service may include the following components: o 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. o 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. o Facilitate participation in and utilization of strengths-based planning and treatments, which include assisting the beneficiary and family members or other collaterals with identifying strengths and needs, resources, natural supports, and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their mental illness and/or SUD.

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PROMISE Eligibility Criteria and Service Definitions

PROMISE Service	Service Definition
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. ○ Provide restoration, rehabilitation, and support to develop skills to locate, rent, and keep a home, to enable landlord/tenant negotiations; to select a roommate and to understand and exercise renter's rights and responsibilities. ○ Assist the beneficiary to develop daily living skills specific to managing their own home including managing their money, medications, and using community resources and other self-care requirements. ○ Implement interventions using evidence-based techniques, drawn from cognitive-behavioral therapy and other evidence-based psychotherapeutic interventions that ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom manifestation.
Community-based residential alternatives supports that exclude assisted living	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). 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. ADLs include tasks related to caring for and moving the body. ADLs include: • Walking. • Bathing. • Dressing. • Toileting. • Brushing teeth. • Eating.

Community-based residential alternatives supports that exclude assisted living (cont'd)	IADLs are the activities are not directly related to functional activities, rather they are an additional set of more complex life functions necessary for maintaining a person's immediate environment and living independently in the community. IADLs include: • Cooking and meal planning. • Performing ordinary housework. • Getting around in the community. • Using the telephone or computer. • Shopping for groceries. • Supporting the beneficiary in exploring employment opportunities . • Keeping track of finances. • Managing medication, including assisting with setting up medication administration mechanisms (e.g. pill jars) and ensuring that individuals have the supports necessary to timely take medications (Not appropriate for Peer Specialists). The provider will be encouraged to hire staff to deliver personal care services separate from staff who provide habilitation services that involved the development of ADL and IADL skills, if there is more than one staff member on site at the residence during normal hours, who can provide personal care services. This will ensure that the clinical boundary issues that would otherwise complicate habilitation services (if the same staff were also delivering personal care services) will be mitigated. Services must be delivered in a manner that supports the beneficiary's communication needs including, but not limited to age appropriate communication, translation services for beneficiaries that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding and use of communication devices used by the beneficiary. The cost of transportation provided by residential service providers to and from activities is included as a component of the residential services and; therefore, is reflected in the rate for the service. Providers of residential services are responsible for the full range of transportation services needed by the beneficiaries they serve to participate in services and activities specified in their Recovery Plan. This includes transportation to and from daily activities and employment services, as applicable. The service provider must maintain documentation in accordance with department requirements. The documentation must be available to the care manager for monitoring at all times on an ongoing basis. The care manager will review the authorized tier on an ongoing basis and monitor the community character of the residence during regularly scheduled contact with the beneficiary. Results of this monitoring will be reported to the department. If the monitoring suggests that a change in tiers is needed, the care manager will recommend a re-assessment to re-evaluate the beneficiary to determine the appropriateness of the assigned tier in accordance with department requirements. The following levels of residential services are available to beneficiaries as determined necessary, based upon a quarterly assessment, documented in the Recovery Plan and approved by the department. Model 1 — habilitative supports in the home (the beneficiary is encouraged to seek BH treatment for SPMI in the community) (Tiers 1 and 2). **Tier 1: A beneficiary requires:** • Limited supervision as the beneficiary is able to make safe decisions when in familiar surroundings, but requires occasional increased need for assistance or to address unanticipated needs, with supports available on a 24-hour on call or as-needed basis, AND • Incidental or intermittent hands-on assistance or cueing for at least one ADL and at least one IADL, OR • Incidental or intermittent hands-on assistance or cueing with at least three IADLs, OR

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

- 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).

Tier 2: A beneficiary requires:

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

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

Tier 3: A beneficiary requires:

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

PROMISE Service	Service Definition

Special care unit services.

Tier 4: A beneficiary requires:

- Extensive support and cannot be left alone for any period throughout the day, as determined by an
  assessment or clinical determination of need for continuous supervision, due to a significant risk
  for recent or ongoing occurrences of behavior in which the beneficiary is a threat to self or others.
- **Medical Necessity criteria for Tier4 includes meeting the following:**
  ASAM Criteria

Can have high immediate need profile

1. Substance abuse — can have current potential (fifth choice)
2. Biomed — up to "current/unstable"
3. Suicidality — any level not needing acute
   a. Suicidality – control/impulsivity — has moderate- high risk for problems
   b. **Dangerousness — highest risk that does not require inpatient**
   c. Self-care — any level, but will tend to not seek treatment without assistance, and require assistance in personal care, life skills (see PROMISE service descriptions) or other ASAM items checked
   d. Psychological/ emotional health — any level or
4. Readiness to change — any level or
5. Relapse, etc. — any level (except for those in 3–5 day beds, which will probably have high need on 3 and on 5)

Community Living Questionnaire

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

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

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PROMISE Eligibility Criteria and Service Definitions

PROMISE Service	Service Definition
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: • Assist the client in developing financial strategies to reach participant's goals with care to ensure that personal strategies reflect considerations related to benefits, as identified through benefits counseling; • Ensure that individuals understand the availability of various tax credits such as the Earned Income Tax Credit, Child Care Tax Credit, and others; • Refer individuals as needed to benefit counselors; • Provide information to complement information provided through benefits counseling regarding appropriate asset building; • Use an integrated dashboard of available community-based asset building opportunities and financial tools/services to ensure participants are leveraging all resources to increase economic self-sufficiency; • Provide information about how to protect personal identify and avoid predatory lending schemes; • Provide assistance with filing yearly taxes either through the IRS VITA program or its virtual program that involves self-filing. The Financial Coaching Plus service will include the collection and maintenance of proper documentation of services provided as required by the Department that will track goals, actions, and outcomes of individual participants. The Financial Coaching Plus service may complement information provided on the use of public benefits and/or work incentives through Benefits Counseling or other services. 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

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PROMISE Service	Service Definition
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. 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. IADL services consist of the performance of general household tasks (e.g., meal preparation, cleaning, laundry, and other routine household care) provided by a qualified homemaker when the beneficiary regularly responsible for these activities is absent or unable to manage the home and care for him or herself or others in the home, or when no landlord or provider agency staff is responsible to perform the IADL services. Chore services consist of services provided to maintain the home in a clean, sanitary, and safe condition. This service includes heavy household chores, such as: • Washing floors, windows, and walls. • Tacking down loose rugs and tiles. • Moving heavy items of furniture in order to provide safe access and egress. • Removing ice, snow and/or leaves. • Yard maintenance. The providers of this service must review and be familiar with the crisis support plan. IADL/chore services may not be billed at the same time as personal care or respite services. IADL/chore services are limited to 40 hours per beneficiary per 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.

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

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

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

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

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

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

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

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PROMISE Service	Service Definition
	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. • Assisting beneficiaries in making informed decisions about whether to disclose their mental illness condition to employers and co-workers. • Intensive IESS includes assisting the beneficiary in meeting employment expectations, performing business functions, addressing issues as they arise, and also includes travel training, and diversity training to the specific business where the beneficiary is employed. Intensive IESS provides support to assist beneficiaries in stabilizing in an integrated situation (including self-employment) and may include activities on behalf of the beneficiary when the beneficiary is not present to assist in maintaining job placement. Once the beneficiary is stable in the position, extended follow along will ensue. 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 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. Transportation services consist of: • Transportation (mile): This transportation service is delivered by providers, family members, and other qualified, licensed drivers. Transportation (mile) is used to reimburse the owner of the vehicle or other qualified, licensed driver who transports the beneficiary to and from services and resources related to outcomes specified in the beneficiary's Recovery Plan. The unit of service is one mile. Mileage can be paid round trip. A round trip is defined as from the point of first pickup to the service destination and the return distance to the point of origin. When transportation (mile) is provided to more than one beneficiary at a time, the provider will divide the shared miles equitably among the beneficiaries to whom transportation is provided. The provider is required (or it is the legal employer's responsibility under the Vendor Fiscal/Employer Agent model) to track mileage, allocate a portion to each beneficiary, and provide that information to the care manager for inclusion in the beneficiary's Recovery Plan. • Public transportation: The utilization of public transportation promotes self-determination and is made available to beneficiaries as a cost-effective means of accessing services and activities. This service provides payment for the beneficiary's use of public transportation. 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

PROMISE Service	Service Definition
	community and ensure the health, welfare, and safety of the beneficiary. This service is intended to be utilized in the beneficiary's home. Services are provided by a 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. 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. • Short-term or intermittent nursing: Nursing that is provided on a short-term or intermittent basis, not expected to exceed 75 units of service in a Recovery Plan year and are over and above services available to the beneficiary through the State Plan. • Long-term or continuous nursing: Long-term or continuous nursing is needed to meet ongoing assessed needs that are likely to require services in excess of 75 units per Recovery Plan year, are provided on a regular basis and are over and above services available to the beneficiary through the State Plan. Services must be delivered in a manner that supports the beneficiary's communication needs including, but not limited to age appropriate communication, translation services for beneficiary's that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding and use of communication devices used by the beneficiary. • The nursing service provider must maintain documentation in accordance with department requirements. The documentation must be available to the care manager for monitoring at all times on an ongoing basis. The care manager will monitor on a quarterly basis to see if the objectives and outcomes are being met.

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

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PROMISE Eligibility Criteria and Service Definitions

PROMISE Service	Service Definition
PS (cont'd)	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. 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. This service may include the following components: • Helps beneficiaries aspire to and attain roles which emphasize their strengths by: o Sharing parts of their own personal recovery story and first hand experiences. Providing mutual support, hope, reassurance, and advocacy. o Provides PS to beneficiaries regarding understanding their symptoms of mental illness and effects of trauma and trauma history, developing positive coping skills. o Engaging beneficiaries through outreach and support. o Assists beneficiaries to advocate for self and others. o Promotes recovery through modeling by: ▪ Sharing one's own personal recovery story.

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

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

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

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

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PROMISE Service	Service Definition
	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. 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: • Care to assist with daily living activities (e.g., eating, bathing, dressing, personal hygiene), cueing to prompt the beneficiary to perform a task and providing supervision to assist a beneficiary who cannot be safely left alone. • Health maintenance, such as bowel and bladder routines, ostomy care, catheter, wound care, and range of motion, as indicated in the beneficiary's Recovery Plan and permitted under applicable State requirements. • Routine support services, such as meal planning, keeping of medical appointments, and other health regimens needed to support the beneficiary. • Care and implementation of prescribed therapies. • Overnight personal care services to provide intermittent or ongoing awake, overnight care to a beneficiary in their home for up to eight hours. Overnight personal care services require awake staff. Personal care may include care with the following activities when incidental to personal care and necessary to complete ADLs: • Activities that are incidental to the delivery of the personal care to assure the health, welfare, and safety of the beneficiary such as changing linens, doing the dishes associated with the preparation of a meal, laundering of towels from bathing may be provided and must not comprise the majority of the service. Services to accompany the beneficiary into the community for purposes related to personal care, such as shopping in a grocery store, picking up medications, and providing care with any of the activities noted above to enable the completion of those tasks.
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. **Definitions** PSR services are designed to assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness and/or SUD. Activities included must be intended to achieve the identified goals or objectives as set forth in the beneficiary's Recovery Plan. The intent of PSR is to restore the fullest possible integration of the beneficiary as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention. PSR is a face-to-face intervention with the beneficiary present. Services may be provided individually or in a group setting and should utilize (with documentation) evidence-based rehabilitation interventions. Group PSR sessions may not include more than eight beneficiaries in attendance. This service may include the following components: • Restoration, rehabilitation, and support with the development of social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase

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	community awareness, develop coping strategies, and effective functioning in the beneficiary's social environment including home, work, and school. • Restoration, rehabilitation, and support with the development of daily living skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a beneficiary's daily living. Supporting the beneficiary with development and implementation of daily living skills and daily routines critical to remaining in home, school, work, and community. • Assisting the beneficiary with implementing learned skills so the beneficiary can remain in a natural community location. • Assisting the beneficiary with effectively responding to or avoiding identified precursors or triggers that result in functional impairments. • Ongoing in-vivo assessment of the beneficiary's functional skill and impairment levels that is used to select PSR interventions and periodically assess their effectiveness. Workers who provide PSR services should periodically report to a supervising licensed practitioner on the beneficiaries' progress toward the recovery and re-acquisition of skills.
Respite	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. Respite services may include the following activities: • Assistance with the beneficiary's social interaction, use of natural supports and typical community services available to all people and participation in volunteer activities. • Activities to improve the beneficiary's capacity to perform or assist with activities of daily living and instrumental activities of daily living. • Onsite modeling of behavior, behavior support, intensive behavior episode intervention, training, cueing, and/or supervision. **Respite 15-minute Unit** Respite (15-minute unit) may be provided in the beneficiary's home or out of the beneficiary's home (not in a facility) in units of 15-minutes, for up to 12 hours a day. It is intended to provide short-term respite. **Respite Per diem** Respite (per diem) may be provided in a facility on a per diem basis. It is intended to provide short-term respite. 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. 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.
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)

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	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. 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. 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. 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.

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

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

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

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

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

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

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

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

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	The short-term small group supported employment supports service provider must maintain documentation in accordance with department requirements. The documentation must be available to the care manager for monitoring at all times on an on-going basis. The care manager will monitor on a quarterly basis to see if the objectives and outcomes are being met. Competitive and integrated employment, including self-employment, shall be considered the first option when serving persons with disabilities who are of working age.
Community Transitions 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.

ATTACHMENT E

HCBS Participant Safeguards and DSHP-Plus Level of Care Criteria

I. Critical Events or Incidents

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

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

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

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

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

In Delaware, a critical event or incident is referred to as an "incident" under

DLTCRP's Investigative Protocol. Under Delaware law, an incident can be defined as anything that has a negative outcome on the resident. For APS, critical events or incidents (as defined in Title 31, Chapter 39 §3910) include abuse, mistreatment, exploitation, and neglect. In addition, APS investigates cases of inadequate self-care (self-neglect) and disruptive behavior.

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

II. Member Training and Education

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

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

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

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

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

appropriate victim assistance services are implemented immediately.

2. The Division of Family Services within the Department of Services for Children, Youth and Their Families is the designated agency to receive, investigate, and respond to critical incidents of abuse or neglect of children living in the community.

3. Per, any person, agency, organization or entity who knows or in good faith suspects child abuse or neglect must make a report to the Division of Family Services.

IV. Quality Oversight and Improvement

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

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

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

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

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

APS staff members participate in the overall quality management strategy by providing feedback to the MCO and DMMA. Staff representatives from DLTCRP and OSO are available to meet with the QIC quarterly and on an as-needed basis.

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

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

Medical Eligibility Determinations

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

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

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

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

Nursing Facility Level of Care– PAS determines that an individual requires an NF LOC when

the individual requires assistance with at least two ADLs. This LOC requirement only applies to individuals newly entering a NF. All individuals receiving services in a NF prior to implementation of DSHP Plus will be grandfathered at the LOC requirement of requiring assistance with at least one ADL as long as they continue to require assistance with at least one ADL. In addition, children residing in the community are medically eligible under TEFRA if they are determined to require a NF LOC.

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

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

Pre-Admissions Screening and Resident Reviews (PASRR)

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

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

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

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

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

ATTACHMENT F

Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform both Congress and CMS about Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs

All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals.

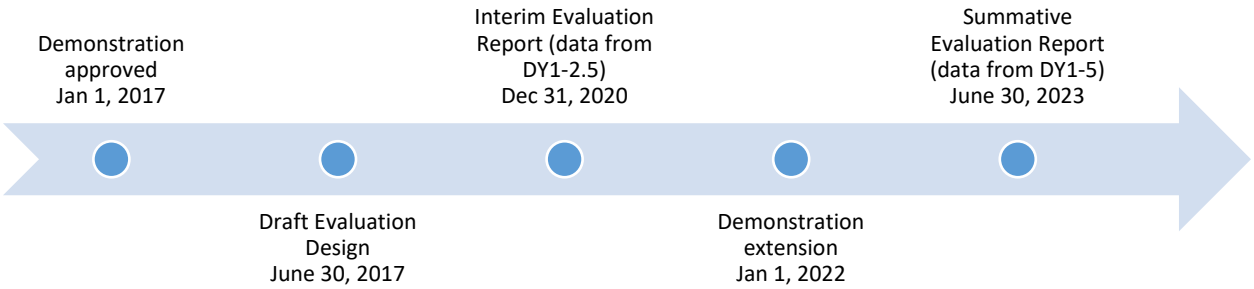
The format for the Evaluation Design is as follows:
General Background Information;
Evaluation Questions and Hypotheses;
Methodology;
Methodological Limitations;
Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.

ATTACHMENT F

Developing the Evaluation Design



Required Core Components of All Evaluation Designs
The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).

2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;

4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.

2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf

3) Identify the state's hypotheses about the outcomes of the demonstration:

4) Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;

5) Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology.

The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?

2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3) *Evaluation Period* – Describe the time periods for which data will be included.

ATTACHMENT F

Developing the Evaluation Design

4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:

    a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.

    b. Qualitative analysis methods may be used, and must be described in detail.

    c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.

    d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

    e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).

    f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

    If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:

    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.

b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.

c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).

d. The application of sensitivity analyses, as appropriate, should be considered.

7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review. For example:

1) When the state demonstration is:
   a. Long-standing, non-complex, unchanged, or
   b. Has previously been rigorously evaluated and found to be successful, or

   c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)
2) When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
   a. Operating smoothly without administrative changes; and
   b. No or minimal appeals and grievances; and
   c. No state issues with CMS-64 reporting or budget neutrality; and
   d. No Corrective Action Plans (CAP) for the demonstration.

E. Attachments

1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include "No Conflict of Interest" signed by the independent evaluator.

2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

ATTACHMENT G
Preparing the Interim and Summative Evaluation Reports

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. As these valid analyses multiply (by a single state or by multiple states with similar demonstrations) and the data sources improve, the reliability of evaluation findings will be able to shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Guidance

The Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Guidance is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

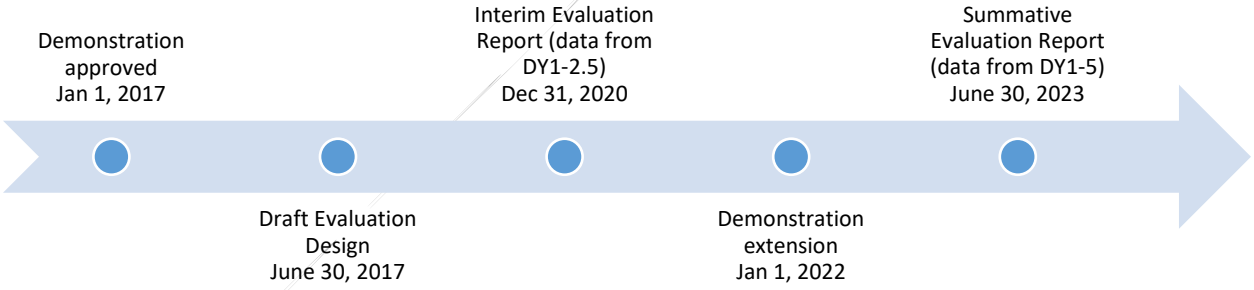
ATTACHMENT G
Preparing the Interim and Summative Evaluation Reports

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish to the state's website the evaluation design within thirty (30) days of CMS approval, and publish reports within thirty (30) days of submission to CMS , pursuant to 42 CFR 431.424. CMS will also publish a copy to Medicaid.gov.



ATTACHMENT G
Preparing the Interim and Summative Evaluation Reports

Required Core Components of Interim and Summative Evaluation Reports
The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design guidance) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.

2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;

4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

2) Identify the state's hypotheses about the outcomes of the demonstration;
   a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
   b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
   c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design.

The evaluation design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Evaluation Design* – Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc.?
2. *Target and Comparison Populations* – Describe the target and comparison populations; include inclusion and exclusion criteria.
3. *Evaluation Period* – Describe the time periods for which data will be collected
4. *Evaluation Measures* – What measures are used to evaluate the demonstration, and who are the measure stewards?
5. *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data.
6. *Analytic methods* – Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations - This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results.

1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:

    a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1. What lessons were learned as a result of the demonstration?

2. What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment - Evaluation Design: Provide the CMS-approved Evaluation Design.

ATTACHMENT H

Reserved for the Evaluation Design

ATTACHMENT I

SUD Implementation Plan

Delaware Health and Social Services

Division of Medicaid & Medical Assistance

Delaware Diamond State Health Plan (DSHP)

Section 1115 Demonstration Waiver

SUD Implementation Plan

State of Delaware

Stephen Groff, Director

Division of Medicaid & Medical Assistance (DMMA)

OCTOBER 2019

Updated March 2020

DELAWARE SUD 1115 IMPLEMENTATION PLAN

Table I: SUD Implementation Plan

MILESTONE AND STC	CURRENT STATE	FUTURE STATE	SUMMARY OF ACTIONS NEEDED
Access to Critical Levels of Care for OUD and other SUDs (STC #31(a)(i))	Delaware's Medicaid State Plan provides coverage for comprehensive inpatient, outpatient, crisis intervention, residential OUD/SUD services, medically-supervised withdrawal management and MAT, consistent with individuals' assessed treatment needs. Delaware administers its SUD services consistent with ASAM Patient Placement Criteria. Coverage, services and provider qualifications are described in the Delaware Medicaid State Plan, Attachment 3.1 – A, Item 13.d, and in the Delaware Adult Behavioral Health DHSS Service Certification and Reimbursement Manual at https://dhss.delaware.gov/dhss/dsamh/files	2) Not applicable.	3) There are no anticipated actions needed by DMMA for fulfillment of this milestone.

MILESTONE AND STC	CURRENT STATE	FUTURE STATE	SUMMARY OF ACTIONS NEEDED
	/ReimbursementManual.pdf Per Section 3.4.2 of the DSHP MCO Contract, the DSHP benefit package includes: "Substance use disorder services, including all levels of the American Society of Addiction Medicine (ASAM), Medication Assisted Treatment (MAT) and licensed opioid treatment programs"		
Use of Evidence-based, SUD-specific Patient Placement Criteria and Patient Placement (STC #31(a)(ii and iii) a) beneficiaries have access to SUD services at the appropriate level of care b) interventions are appropriate for the diagnosis and	4) In 2010, Delaware adopted Substance Abuse Treatment Standards that integrated ASAM criteria into program standards. 5) 6) Admission guidelines for each level of care are consistent with The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. ASAM criteria are used by providers to determine a	17) DMMA is constantly seeking to improve its review and monitoring of its managed care organizations relative to utilization management. Ongoing review 18) of policies and procedures to ensure they include use of evidence-based practices and SUD-specific 19) criteria will occur to determine if any additional education or changes are warranted.	20) In conjunction with Milestone #6, DMMA's EQRO will perform a focus study to assess MCO and provider application of the ASAM criteria in 2021 (for review of 2020 activities.) Expected report release by August 2021. 21)

MILESTONE AND STC	CURRENT STATE	FUTURE STATE	SUMMARY OF ACTIONS NEEDED
level of care, and c) there is an independent process for reviewing placement in residential treatment settings.	beneficiary's eligibility for SUD services. DMMA does not mandate providers use a specific assessment tool; however, the assessment tool must reflect the ASAM guidelines. 7) The DSHP MCOs are responsible for implementing a utilization management (UM) approach consistent with ASAM Criteria. UM policies and practices are outlined in MCO contracts as well as provider manuals. For PROMISE enrollees who receive behavioral health services in FFS through DSAMH, the medical necessity and utilization management policies are also consistent with ASAM Criteria. Examples of DSHP MCO contract provisions are copied below.		

MILESTONE AND STC	CURRENT STATE	FUTURE STATE	SUMMARY OF ACTIONS NEEDED
	Section 3.12.6.3 of the DSHP MCO Contract requires: 3.12.6.3 Requests for Initial and Continuing Service Authorizations 3.12.6.3.1 The Contractor must have in effect mechanisms to ensure consistent application of review criteria. 8) 3.12.6.3.2 The Contractor shall use the Delaware American Society for Addiction Medicine (DE-ASAM) criteria for behavioral health services. **Section 3.12.4 of the DSHP MCO Contract requires:** 3.12.4 Monitoring of Inpatient Behavioral Health Service Utilization 3.12.4.1 The Contractor shall work with DSAMH to develop a collaboration protocol that includes strategies and agreements to achieve the inpatient behavioral health utilization reduction		

MILESTONE AND STC	CURRENT STATE	FUTURE STATE	SUMMARY OF ACTIONS NEEDED
	targets contained within the DOJ Settlement Agreement. The collaboration agreement, which shall be developed by the Start Date of Operations, shall include at a minimum: 3.12.4.1.1 How the Contractor will monitor adult inpatient behavioral health admissions, readmissions and lengths of stay. 3.12.4.1.2 The process and frequency with which the Contractor will share adult inpatient behavioral health utilization data with DSAMH. 3.12.4.1.3 How the Contractor will collaborate with local emergency rooms and behavioral health providers to appropriately utilize adult inpatient diversion services, such as crisis intervention or other available home and community-based		

MILESTONE AND STC	CURRENT STATE	FUTURE STATE	SUMMARY OF ACTIONS NEEDED
	Covered Services or additional services. 3.12.4.1.4 How the Contractor will collaborate with DSAMH in the admission process, utilization review, and discharge planning for adult members participating in PROMISE. 9) 3.12.4.1.5 How the Contractor will provide ongoing utilization review and directly assist with discharge planning for adult members not participating in PROMISE. 10) **11) The DSHP MCO contract also requires the following key staff position:** 12) 3.20.2.1.4 A full-time Behavioral Health Medical Officer/Medical Director (BH CMO) who is a board certified Psychiatric Mental Health Nurse Practitioner or Clinical Nurse Specialist with an Advanced Practice Nursing (APN)		

MILESTONE AND STC	CURRENT STATE	FUTURE STATE	SUMMARY OF ACTIONS NEEDED
	license in the State of Delaware and has at least five years of combined experience in mental health and substance use services. This person shall oversee and be responsible for all behavioral health activities, including oversight of coordination activities with DSAMH. 13) 14) Examples, of relevant state law include:  SB109.pdf 15) 16)  Engrossment.pdf  SB 41 - Engrossment.pdf		
Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities and	22) See below. 23) 24) 25) 26) 27) 28)	35) Not applicable. 36) 37) 38) 39) 40) 41)	49) There are no anticipated actions needed by DMMA for fulfillment of this milestone. 50)

MILESTONE AND STC	CURRENT STATE	FUTURE STATE	SUMMARY OF ACTIONS NEEDED
Standards of Care (STC #31(a)(iv)-(vi)) a) Implementation of residential treatment provider qualifications (in licensure requirements, policy manuals, managed care contracts, or other guidance) that meet the ASAM Criteria or other nationally-recognized, SUD-specific program standards regarding the types of services, hours of clinical care and credentials of staff for residential treatment settings;	29) In 2010, Delaware adopted Substance Abuse Treatment Standards that establish integration of ASAM criteria into OUD/SUD treatment program standards. The standards also address licensure criteria and suspension and revocation of licensure. 30) Residential treatment providers must be a licensed organization, pursuant to the residential service provider qualifications described in Title 16, DHSS, Delaware Administrative Code, Section 6001, 4.1. 31) The DSAMH Licensed and Certified Provider Directory contains licensure information for all substance abuse programs that are licensed by the Division of Substance Abuse and Mental Health in the state of Delaware. Currently, a provider's licensure status is identified	42) Delaware is considering updates to the provider qualifications in State rules. 43) 44) 45) 46) 47) 48)	

MILESTONE AND STC	CURRENT STATE	FUTURE STATE	SUMMARY OF ACTIONS NEEDED
b) Implementation of a state process for reviewing residential treatment providers to assure compliance with these standards; and c) Implementation of a requirement that residential treatment facilities offer MAT on-site or facilitate access off-site.	(e.g., Full or Provisional) as well as the name of the service the provider delivers (e.g., Residential Services). 32) 33) The Delaware Division of Substance Abuse and Mental Health (DSAMH), part of DHSS, is responsible for assuring continual compliance through reviews of residential treatment centers for compliance with these standards. 34) The State Plan definition of residential addiction services includes MAT when medically necessary, including the direct administration of medication.		
Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (STC #31(a)(vii)	Gaps remain in the service delivery continuum for many of Delaware's most at risk and underserved groups, including Medicaid beneficiaries. An essential component of ensuring that Medicaid beneficiaries receive	51) The assessment under the SUPPORT Act Grant will inform infrastructure improvements to increase provider capacity to provide OUD and other SUD treatment and recovery services in Medicaid and help establish a long-term	52) In September 2019, CMS awarded Delaware a SUPPORT ACT Section 1003 Project Planning Grant to assess the Mental Health and SUD treatment needs of the State of Delaware. The aims of the proposed

MILESTONE AND STC	CURRENT STATE	FUTURE STATE	SUMMARY OF ACTIONS NEEDED
	treatment and recovery services is ensuring access to continuum of care that is timely, comprehensive, evidence-based, and sustainable. This includes a pipeline of clinical and nonclinical providers skilled in working with Medicaid beneficiaries around opioid use disorder (OUD) and other SUD, a cohesive health system that allows for seamless movement between treatment levels and providers, and payment models that support providers.	data collection and monitoring plan.	assessment of the mental health and SUD treatment needs of the State of Delaware (the assessment) are to: 1) Understand the mental health and substance abuse treatment needs of the population receiving Medicaid in the state, and 2) Determine the extent to which additional providers are needed to address Medicaid beneficiaries' unmet SUD treatment and recovery needs. 53) By December 2020 (or as updated in the SUPPORT Act Grant), as described in Delaware's SUPPORT Act Project Planning Grant, Delaware will: 54) 1.Estimate the number and percentage of OUD

MILESTONE AND STC	CURRENT STATE	FUTURE STATE	SUMMARY OF ACTIONS NEEDED
			and other SUD among Medicaid-beneficiaries, and OUD and other SUD treatment and recovery needs. 55) 2. Complete a workforce assessment to determine SUD provider and service capacity for Medicaid beneficiaries. 56) 3. Conduct a gaps analysis to determine service gaps to treating the OUD and other SUD needs of Medicaid-covered SUD treatment and recover services. 57) DMMA recognizes that these steps, as planned for in the SUPPORT Act Planning Grant, are slightly longer than the 12 months requested by CMS for SUD 1115 Waivers. However, we are requesting that CMS permit DMMA to align our efforts between the 1115 and the SUPPORT Act Grant activities to focus on one review of provider capacity at critical levels of care. If the Support Act Grant dates are revised by mutual

MILESTONE AND STC	CURRENT STATE	FUTURE STATE	SUMMARY OF ACTIONS NEEDED
			agreement between Delaware and CMS, DMMA will seek CMS approval for a corresponding update to the Implementation Plan.
Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (STC #31(a)(viii)) a) implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse b) expanded coverage of, and access to, naloxone for overdose reversal c) implementation of strategies to increase utilization and improve functionality of prescription drug	(a) Effective April 1, 2017 the Delaware Uniform Controlled Substance Act rules and regulations were revised to add a new Section 9.0 pertaining to the safe prescribing of opioid analgesics: Safe Prescribing of Opioid Analgesics. 58) This Section provides requirements for the prescribing of opioid analgesics in order to address potential prescription drug overdose, abuse, and diversion and encourage the proper and ethical treatment of pain. Pursuant to the requirements of this Section, the practitioner can meet the goal of addressing drug overdose, abuse and diversion while ensuring patient access to safe and effective pain care.	62) Not applicable. 63)	64) There are no anticipated actions needed by DMMA for fulfillment of this milestone.

MILESTONE AND STC	CURRENT STATE	FUTURE STATE	SUMMARY OF ACTIONS NEEDED
monitoring programs	59) (b) Pharmacists can now dispense the overdose antidote over the counter under SB 48 (attached).  SB 48 - Engrossment.pdf 60) 61) (c) The Delaware Prescription Monitoring Act (16 Del. C.§ 4798) authorizes the Office of Controlled Substances (OCS) in the Delaware Division of Professional Regulation to establish, maintain and monitor the Prescription Monitoring Program (PMP). The purpose of the PMP is to reduce misuse of controlled substances in Delaware and to promote improved professional practice and patient care. The Delaware Prescription Drug Monitoring Program Advisory		

MILESTONE AND STC	CURRENT STATE	FUTURE STATE	SUMMARY OF ACTIONS NEEDED
	Committee regularly focuses on strategies to improve functionality of the PDMP. Examples from the September meeting are attached.  63279_Minutes-... (d) There are no copays on Nalaxone. For up-to-date details on Delaware's initiatives to expand access to Naloxone, see the Overdose Prevention section on helpisherede.com		
SUD HIT Plan (STC #31(a)(ix)	See Table II	65)	66)
Improved Care Coordination and Transitions between Levels of Care (Implementation of policies to ensure residential and inpatient facilities link	67) ASAM level of care guidelines require that residential facilities begin discharge/transfer planning services upon a beneficiary's admission. In addition, programs must provide referral and assistance as	DMMA will continue to monitor MCO compliance with existing contract requirements in effort to assure beneficiary needs are met relative to linkage with community-based services.	77) DMMA's EQRO will perform a focus study to assess MCO performance on Care Coordination and Transitions between Levels of Care for individuals with OUD and other SUD in 2021 (for review of 2020 activities.) Since

MILESTONE AND STC	CURRENT STATE	FUTURE STATE	SUMMARY OF ACTIONS NEEDED
beneficiaries with community-based services and supports following stays in these facilities.) (STC #31(a)(x)	needed for beneficiaries to gain access to other needed SUD or mental health services. 68) 69) Examples of relevant DSHP MCO Contract language includes: 70) 3.6.4 Clinical Practice Guidelines 3.6.4.1 The Contractor's care coordination program shall utilize evidence-based practice guidelines. 71) 3.6.4.2 The Clinical care coordination program shall be described and included in the contractor's utilization management program description. 72) 3.6.3.3 Level 1: Resource Coordination 73) 3.6.3.3.1 The Contractor shall actively assist providers in discharge planning for Level 1 members following acute episodes of care involving at a minimum one of the following services:	76)	PROMISE enrollees are also enrolled in DSHP MCOs, the EQRO will include a review of care coordination and care transitions for MCO members receiving PROMISE services in FFS. Expected report release by August 2021. 78) 79) DMMA will determine if additional policies to ensure coordination of care for co-occurring physical and mental health conditions are needed: July 2020 (assessment) and September 2021 (implementation as needed, to align with the release of the EQRO special study results.)

MILESTONE AND STC	CURRENT STATE	FUTURE STATE	SUMMARY OF ACTIONS NEEDED
	inpatient psychiatric stay, ambulatory surgery, hospital inpatient stay, and rehabilitation facility services. Contractor assistance shall include but not be limited to: appointment setting, referrals and linkages to services, coordination of DME, and coordination of prior authorizations as needed to support the member's timely access to services in the community. 74) 3.8.4.2.3 The Contractor shall actively assist with discharge planning when members are receiving behavioral health services within higher levels of care including institutional or residential settings. 75) 3.8.4.2.4 The Contractor shall work with Treatment Access Center case managers in providing treatment for drug court related cases.		

Table II. Delaware SUD HIT Plan

Section I

MILESTONE AND STC	CURRENT STATE	FUTURE STATE	SUMMARY OF ACTIONS NEEDED
PDMP Functionalities: Enhanced interstate data sharing in order to better track patient specific prescription data.	The Delaware PMP is part of the PMP Interconnect (PMPi). Delaware is currently connected with 35 states, Puerto Rico, and the Department of Defense.	The PMP is authorized in state law until 2025. The Delaware Department of Public Health received a CDC Overdose Data to Action (ODTA) grant that will be utilized, in part, to maintain and enhance the PMP for the next 3 years.	80) There are no anticipated actions needed by DMMA for fulfillment of this milestone. Delaware will include regularly-occurring updates in the SUD Monitoring Plan.
PDMP Functionalities: Enhanced "ease of use" for prescribers and other state and federal stakeholders	The PMP Advisory Committee (https://dpr.delaware.gov/boards/pmp/) focuses on prescriber tools and enhanced "ease of use" at its regular meetings. Examples of recent enhancements to the PMP include: allowing users to more easily reset their password via text message (in response to feedback received in the 2018 PMP user survey); improved quarterly prescriber reports that provide information such as	The PMP Advisory Committee will continue to seek feedback from prescribers and make improvement that enhance ease of use.	81) There are no anticipated actions needed by DMMA for fulfillment of this milestone. 82) Delaware will include regularly-occurring updates in the SUD Monitoring Plan.

MILESTONE AND STC	CURRENT STATE	FUTURE STATE	SUMMARY OF ACTIONS NEEDED
	simplified format, clearer specialty comparison, trend data, and per patient statistics, as requested through prescriber feedback (under development.)		
PDMP Functionalities: Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange	Currently the Delaware PMP is part of the PDMP interconnect collaboration with Appriss Health and the National Association of Boards of Pharmacy, which is the national PDMP data exchange hub that enables the secure sharing of PDMP data across states and systems. Delaware's DHIN (HIE) links to the PMP. Approximately 57 health systems/provider practices and 160 pharmacies have integrated access to the PMP. Delaware was also selected to pilot integration with the Veteran's Administration.	Delaware intends to continue to promote integration of the PMP into provider/health systems.	83) There are no anticipated actions needed by DMMA for fulfillment of this milestone. 84) Delaware will include regularly-occurring updates in the SUD Monitoring Plan.

MILESTONE AND STC	CURRENT STATE	FUTURE STATE	SUMMARY OF ACTIONS NEEDED
PDMP Functionalities: Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns	State law requires practitioners to query the PMP for subsequent prescriptions (beyond the first) and chronic pain patients. State law also explicitly authorizes the use of the PMP in a number of circumstances designed to identify long-term opioid use and/or use for reasons other than treatment of an existing medical condition. Details can be found at: https://delcode.delaware.gov/title16/c047/sc07/		85) There are no anticipated actions needed by DMMA for fulfillment of this milestone. 86) Delaware will include updates in the SUD Monitoring Plan.
Current and Future PDMP Query Capabilities: Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state's master patient index (MPI) strategy with regard to PDMP query)	As noted in the SMHP, the Community Health Record (CHR) within the DHIN (Delaware's HIE with the MPI data) has Medication History. The DHIN links to the PMP. Users of the CHR can retrieve 12 months of prescription fill history (provided by a number of national sources, to include		Delaware will report on future planned PDMP query capabilities within 6 months of CMS approval of the SUD HIT Plan and provide regular updates as part of the Monitoring Report.

MILESTONE AND STC	CURRENT STATE	FUTURE STATE	SUMMARY OF ACTIONS NEEDED
	SureScripts, health plan pharmacy benefits managers, and others) upon demand. For those who do not choose to subscribe to the full service, there is a URL link embedded in the DHIN web portal that takes the user to the Delaware Prescription Monitoring database, where they can at minimum (and for no charge) view the controlled substance fill history for the patient.		
Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes: Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow Develop enhanced supports for clinician	The PMP Advisory Committee (https://dpr.delaware.gov/boards/pmp/) focuses on prescriber tools and administrative/analytics at its regular meetings and makes regular enhancements to the PMP in support of clinicians with changing office workflows and business processes. Approximately 57 health systems/provider practices and 160		87) There are no anticipated actions needed by DMMA for fulfillment of this milestone. 88) Delaware will include updates in the SUD Monitoring Plan.

MILESTONE AND STC	CURRENT STATE	FUTURE STATE	SUMMARY OF ACTIONS NEEDED
review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription	pharmacies already have integrated access to the PMP. Section 3.10.2.1.24 of the MCO contracts requires participating providers to comply with the requirements of the Delaware Prescription Monitoring Program (PMP) and to query the PMP to view information about client usage before prescribing Schedule II or III controlled substances.		
Master Patient Index / Identity Management: Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.	As noted in the SMHP, the Community Health Record within the DHIN (Delaware's HIE) has Medication History. Users of the CHR can retrieve 12 months of prescription fill history (provided by a number of national sources, to include SureScripts, health plan pharmacy benefits managers, and others) upon demand. For those who do not choose to subscribe to the full service, there is a URL link embedded in the DHIN web		DMMA will report on any planned future enhancements in support of SUD care delivery and the status of implementation within 6 months of CMS approval of the SUD HIT Plan.

MILESTONE AND STC	CURRENT STATE	FUTURE STATE	SUMMARY OF ACTIONS NEEDED
	portal that takes the user to the Delaware Prescription Monitoring database, where they can at minimum (and for no charge) view the controlled substance fill history for the patient.		
Overall Objective for Enhancing PDMP Functionality & Interoperability: Leverage the above functionalities / capabilities / supports (in concert with any other state health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Medicaid does not inappropriately pay for opioids	In accordance with CDC guidelines, Delaware has implemented maximum quantity and dosage limits for opioid prescriptions for intractable, non-cancer pain, helping to ensure that Medicaid does not inappropriately pay for opioids.		Within 6 months of CMS approval of the SUD IP, Delaware will provide and update description of the future state and updates on actions need.

Delaware assures that it has a sufficient health IT infrastructure/ “ecosystem” at every appropriate level (i.e. state, delivery system, MCO and individual provider) to achieve the goals of the demonstration. The SUD Health IT Plan is aligned with the SMHP. Delaware will continue to make ongoing enhancements to the PMP over the life of the demonstration as needs are identified. Delaware will report on these enhancements in the SUD Monitoring Plan.

Section II – Implementation Administration

Please provide the contact information for the state’s point of contact for the SUD Health IT Plan.

Name and Title: Glyne Williams, Chief—Policy, Planning and Quality
Telephone Number: (302) 255-9628
Email Address: Glyne.Williams@delaware.gov

Section III – Relevant Documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan.

Attached is the most recent version of the SMHP.

2018 DE SMHP.pdf

ATTACHMENT J

Reserved for SUD Monitoring Protocol

ATTACHMENT K

Reserved for Contingency Management Protocol

ATTACHMENT L

Reserved for Food Box and Diaper Initiative Protocol