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State/Territory Name: Delaware

State Plan Amendment (SPA) #: 24-0013

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

December 20, 2024

Andrew Wilson, Medicaid Director
Division of Medicaid and Medical Assistance
Delaware Department of Health & Human Services
1901 North Dupont Highway
New Castle, DE 197209

RE: 24-0013 Pathways to Employment §1915(i) home and community-based services (HCBS) state plan benefit renewal

Dear Mr. Wilson :

The Centers for Medicare & Medicaid Services (CMS) is approving the state's 1915(i) state plan home and community-based services (HCBS) state plan amendment (SPA), transmittal number 24-0013. The purpose of this amendment is to renew Delaware's 1915(i) State Plan HCBS benefit. The effective date for this renewal is January 1, 2025. Enclosed is a copy of the approved SPA.

Since the state has elected to target the population who can receive these §1915(i) State Plan HCBS, CMS approves this SPA for a five-year period expiring December 31, 2029 in accordance with §1915(i)(7) of the Social Security Act. To renew the §1915(i) State Plan HCBS benefit for an additional five-year period, the state must submit a renewal application to CMS at least 180 days prior to the end of the approval period. CMS' approval of a renewal request is contingent upon state adherence to federal requirements and the state meeting its objectives with respect to quality improvement and beneficiary outcomes.

Per 42 CFR §441.745(a)(i), the state will annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in the §1915(i) State Plan HCBS in the previous year. Additionally, at least 21 months prior to the end of the five-year approval period, the state must submit evidence of the state's quality monitoring in accordance with the Quality Improvement Strategy in their approved SPA. The evidence must include data analysis, findings, remediation, and describe any system improvement for each of the §1915(i) requirements.

CMS reminds the state that the state must have an approved spending plan in order to use the money realized from section 9817 of the ARP. Approval of this action does not constitute approval of the state's spending plan.

It is important to note that CMS' approval of this 1915(i) HCBS state plan benefit renewal solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

If you have any questions concerning this information, please contact me at (410) 786-7561. You may also contact Lekeisha Hosang at lekeisha.hosang@cms.hhs.gov or (215) 861-4278.

Sincerely,

[redacted]

George P. Failla, Jr., Director
Division of HCBS Operations and Oversight

Enclosure

cc: Stacy Watkins, DDDS
Tammi Hessen, CMCS
LaJoshica, Smith, CMCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24 — 0013

2. STATE: DE

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
Title XIX Medicaid State Plan

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 1,704,896
b. FFY 2026 $ 4,313,498

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~3.1-I page 1-63~~
3.1-I page 1-60
4.19-b page 61-66

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
~~3.1-I page 1-63~~
3.1-I page 1-60
4.19-b page 61-66

9. SUBJECT OF AMENDMENT
1915(i) HCBS State Plan Option Amendment Pathways

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:

11. [redacted] AGENCY OFFICIAL

12. TYPED NAME
Andrew Wilson

13. TITLE
Director

14. DATE SUBMITTED
9/19/2024 | 10:51 AM EDT

15. RETURN TO
Andrew Wilson, Director, DMMA
P.O. Box 906
New Castle, DE 19720

16. DATE RECEIVED
09-24-2024

17. DATE APPROVED
December 20, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL [redacted]

20. TYPED NAME OF APPROVING OFFICIAL
George P. Failla, Jr.,

21. TITLE OF APPROVING OFFICIAL
Director

22. REMARKS

12-19-2024 state authorized P&I to box 7 & 8.

Instructions on Back

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

Administration and Operation

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

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

Eligible individuals who have a desire to work in a competitive, integrated environment may receive the following services under this 1915(i) benefit:

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

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

***Select one*:**

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

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

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

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

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

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

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

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

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

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

For items 6 and 7 above, Delaware contracts with a provider relations agent to perform specific administrative functions. Specific functions performed by this contractor include the ongoing enrollment of service providers, execution of the Medicaid provider agreement, and the verification of provider licensure, where applicable, on an annual basis.

Provider relations functions include:

- enrolling service providers
- executing provider agreements

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

5. X **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
   - related by blood or marriage to the individual, or any paid caregiver of the individual
   - financially responsible for the individual
   - empowered to make financial or health-related decisions on behalf of the individual
   - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

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

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

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

Number Served

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

Annual Period	From	To	Projected Number of Participants
Year 1	January 1, 2025	December 31, 2025	705
Year 2	January 1, 2026	December 31, 2026	780
Year 3	January 1, 2027	December 31, 2027	855
Year 4	January 1, 2028	December 31, 2028	930
Year 5	January 1, 2029	December 31, 2029	1005

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

Financial Eligibility

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

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

X The State does not provide State plan HCBS to the medically needy.
☐ The State provides State plan HCBS to the medically needy. (*Select one*):

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

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

Evaluation/Reevaluation of Eligibility

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

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

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

State classification of Assistant Program Administrator conducts the initial evaluation for eligibility. The education and experience for this classification are:

- Possession of an associate degree or higher in Behavioral Health or Social Science or related field and/or,
- Three years experience in case management, which includes assessing, planning, developing, implementing, monitoring, and evaluating options and services to meet a client's human service needs.
- Three years experience in making recommendations as part of a client's service plan such as clinical treatment, counseling, or determining eligibility for health or human services/benefits.
- Six months experience using an automated system to enter, update, modify, delete, retrieve/inquire and report on data.
- Six months experience in narrative report writing.

Knowledge of staff supervision acquired through course work, academic training, training provided through an employer, or performing as a lead worker overseeing the work of others OR supervising staff which may include planning assigning, reviewing, and evaluating the work of others; OR supervising through subordinate supervisors a group of professional, technical and clerical employees.

For all targeted groups, the minimal qualifications for independent individuals performing reevaluation for eligibility are as follows:

State classification of Health/Human Services Case Manager II or equivalent standards for education and experience, with additional disability-specific training provided as needed to effectively perform evaluation. The education and experience for this classification are:

- Possession of an associate degree or higher in Behavioral or Social Science or related field or,
- Experience in health of human services support which includes clients and assessing personal, health, social or financial needs in accordance with program requirements; and coordinating with community resources to obtain client services.
- Experience in making recommendations as part of a client's service plan such as clinical treatment, counseling, or determining eligibility for health or human services benefits.
- Experience in using automated information system to enter, update, modify, delete, retrieve/inquire and report on data.
- Experience in narrative report writing.

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

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

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

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

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

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

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

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

Individuals in this 1915(i) benefit must meet the needs-based criteria described in at least one (1) of the following groups:

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

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

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
Group A Individuals who are Visually Impaired Individuals who need ongoing physical or verbal assistance with performing one ADL and who are at risk of being unable to obtain or sustain competitive employment without this assistance. Group B Individuals with Physical Disabilities Individuals whose physical condition affects their ability to live independently, who need ongoing assistance with at least one ADL and who are at risk of being unable to obtain or sustain competitive employment without supports. Group C Individuals with Intellectual Disabilities, Autism Spectrum Disorders or Asperger's Syndrome. Individuals with significant limitations in adaptive function and/or who need assistance	The individual must have deficits in at least two ADLs.	Individual: 1) Has a diagnosis of intellectual or developmental disability and has been deemed eligible for services through the Division of Developmental Disabilities Services (DDDS). 2) Has been determined to meet ICF/IID level of care based on an assessment completed by a Qualified Intellectual Disability Professional that indicates the individual requires assistance in at least two of the following domains: ADLs, safety, household activities, community access, maintaining relationships, health maintenance, communication, psychological and active treatment services for maximum independence. The diagnosis of Intellectual or Developmental Disability is determined based on: 1) The administration of the Adaptive Behavior Assessment System (ABAS) or Vineland	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

with at least one area of ADL, and/or who have difficulty understanding and interpreting social situations and who are unlikely to be able to obtain or sustain competitive employment without supports.		Adaptive Behavior Scale (VABS) by a licensed psychologist, certified school psychologist or a licensed physician who practices psychiatry who certifies that the individual/applicant has significantly sub-average intellectual functioning or otherwise meets the following criteria: b. An adaptive behavior composite standard score of two or more standard deviations below the mean; or a standard score of two or more standard deviations below the mean in one or more component functioning areas (ABAS: Conceptual, Social; Practical: VABS: Communication; Daily living Skills, Social).	

*Long Term Care/Chronic Care Hospital

**LOC= level of care

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

Delaware defines the following target groups:

Group A	Group B	Group C
Individuals who are Visually Impaired	Individuals with Physical Disabilities	Individuals with Intellectual Disabilities, Autism Spectrum Disorders or Asperger's Syndrome
Individuals age 14 and above determined by a doctor of optometry or ophthalmology	Individuals age 14 and above with a physical disability; whose physical condition is	Individuals age 14 and above with intellectual developmental disorder attributed to one or more of the

to be: totally blind (no light perception), legally blind (20/200 in the better eye with correction, or a field restriction of 20 degrees or less) or severely visually impaired (20/70 to 20/200 in the better eye with correction).	anticipated to last 12 months or more.	following: IQ scores of two standard deviations below the mean, autism spectrum disorder, Asperger's disorder, Prader-Willi Syndrome, as defined in the APA Diagnostic and Statistical Manual, brain injury or neurological condition related to IDD that originates before age 22.

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

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

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

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

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

Home and Community-Based Settings

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

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

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

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

Pathways participants typically live in their own home, the home of a family member (owned or leased by the participant/participant's family for personal use) or a provider managed residential setting. Individuals living in a Medicaid-funded provider managed setting can only be enrolled in Pathways if the setting meets the requirements for HCBS residential settings, as articulated in the HCBS Settings Rule.

Pathways requires that participants reside in a compliant setting, and this is first assessed at the time the initial eligibility determination is made. A participant is not enrolled in the program unless the setting in which they live is compliant. If the service recipient is planning to transition into a compliant HCBS setting, their eligibility will be reviewed at that time. When a participant has moved to a non-compliant setting, prior to disenrollment the Employment Navigator or the Assistant Program Administrator informs the participant of the settings requirements. Disenrollment will be paused for a brief period to allow for the participant and support team to determine whether relocation to a compliant setting is feasible.

If someone is transitioning from a non-compliant setting to a community setting and they are eligible for services, they will be enrolled based upon their transition to a compliant community-based setting. If the service recipient moves from a compliant setting to a non-compliant setting or the setting they are living in is determined to no longer be in compliance with the settings rule, the case manager and/or program administrator would work with the service recipient and their support team to work to have the setting either come into compliance or transition the service recipient to a setting that does meet settings requirements. If the service recipient determines that they do not wish to move from their current living arrangement, only then would program disenrollment take place. Please note, this is only in relationship to settings operated by non-DDDS service providers. If it was a DDDS provider site, they would be required to immediately address and remediate any settings rule compliance issues. If the provider did not address the issues as required, the provider would be disenrolled and the service recipient would be

supported to transition to another setting.

Pathways individuals may receive services in settings that facilitate access to the community and interaction with non-disabled, non-Medicaid individuals. Services may be received in:

- The individual's home that is owned or leased by the individual or individual's family
- Neighborhood Group Home (licensed)
- Community Living Arrangement (non-licensed staffed apartments)
- Shared Living Arrangement (licensed and non-licensed)
- Provider office facilities
- Supported Employment locations (the individual's place of work)
- Community-based public facilities, such as libraries, community centers, and other locations, so long as those settings facilitate interaction with non-disabled, non-Medicaid individuals, and facilitate access to the community

Initially, Provider Surveys were conducted in 2015. Providers used the survey instrument to assess their level of compliance as reflected in their practices and in their policies and procedures.

DDDS conducted desk reviews as a validation measure, to ensure that each survey question was answered, additional comments were provided where required, and to validate responses, to the extent possible, with information DDDS already had on hand.

The DDDS Office of Service Integrity and Enhancement (SIE) performed onsite reviews of a minimum 20% sample of HCBS providers settings, and the DDDS Advisory Council performed oversight, including approving the methodology for selecting the sample and the procedures for conducting the reviews. The 20% sample includes at least one (1) service and setting per provider, inclusive of all settings that were issued a Corrective Action Plan (CAP) during the desk review process. In total 77 settings were selected for an onsite review, which represented all 40 in-state provider agencies at that time. The onsite review team used a standardized tool developed for the onsite review primarily based on the Council on Quality and Leadership (CQL) toolkit and customized for each type of HCBS service.

In total 480 settings were evaluated through the site-specific assessment process. Seventy-seven settings were selected for a look-behind review to be completed by SIE. There were 460 provider settings, including Shared Living that were identified as "compliant with modification" with the most required modification being a residency agreement. During this process, once provider setting was removed from the program. In May of 2024, Delaware completed its CMS approved CAP as all providers were verified as being fully compliant with the Settings Rule requirements.

Delaware implemented a comprehensive approach to ongoing monitoring of providers new to the system and existing providers in the system. The approach consists of obtaining feedback from multiple levels of the system, including but not limited to the person-centered planning process, case manager touch points with members, provider credentialing/recredentialing, provider enrollment and verification processes, and quality reviews. When issues are identified, as appropriate, DMMA, MCOs, DDDS or other operating agencies will work with providers

individually to address non-compliance in a timely fashion. In addition, data is collected and analyzed (on a provider setting level) to track and identify trends and root causes, and to make necessary systems, policy, and/or operational changes to prevent reoccurrence. Also, DDDS will ensure that follow-up occurs in all instances when there is a complaint regarding a non-compliant provider setting.

Monitoring starts with the person-centered employment planning process, the foundation for assessing needs and developing a service plan that addresses identified needs. During this process, when participants select their providers, they are given names of both disability and non-disability specific providers to choose from. The provider network is regularly monitored to ensure that non-disability specific provider settings remain viable options for members. This monitoring will occur through the Quality Service Review (QSR). The QSR annual site surveys based upon DDDS HCBS Provider standards includes all HCB Settings Rule requirements, i.e. right to privacy, has access to their money, etc. A report in the Provider Management system is run to ensure provider sites are compliant.

QSR reviews are conducted by DDDS's Service Integrity and Enhancement unit and are completed at a minimum frequency of annually for each HCBS site. The QSR process conducted by the DDDS's Service Integrity and Enhancement unit includes on-site inspections, record reviews, and a "focus" service recipient survey and interview, to ensure a standardized approach to measuring compliance with DDDS provider standards for HCBS, which are derived in part from the CMS HCBS Settings Rule. DDDS policies and procedures, the person-centered planning process, evaluation of individual outcomes achievement, and the QSR process all include a review to ensure settings compliance. In addition, any time there is an articulated concern that a site may not be in compliance with the setting rule requirements, DDDS investigates either through a potential Right's Violation Complaint or a direct on-site inspection of the site to evaluate and determine if there is a compliance issue that needs to be addressed. Delaware confirms that multiple levels of ongoing monitoring all include a review for compliance with all HCBS settings requirements.

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

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

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

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

delivered in the member's place of work.

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

Person-Centered Planning & Service Delivery

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

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

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

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

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

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

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

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

The person-centered service plan required as per 42 CFR 441.725 may hereafter be referred to in the SPA as the "person-centered employment plan" or simply the "employment plan". Person-centered employment plan development will be conducted by Employment Navigators employed by the State (see Provider Qualifications for the Employment Navigator service under "Services". These individuals must have a minimum of an associate's degree or higher in a behavioral, social sciences or a related field OR having experience in health or human services support, which includes interviewing individuals and assessing personal, health, employment, social or financial needs in accordance with program requirements.

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

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

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

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

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

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

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

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

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

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

Information will be provided to participants in an accessible manner, taking into consideration the participant's unique communication needs. Accommodations will be provided as necessary.

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

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

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

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

Services

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

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

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

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

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

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

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

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

In the performance of the coordinating function;

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

- Coordinates with the participant's family, friends, and other community members to cultivate natural supports.

In the performance of the monitoring function;

• Monitors the health, welfare, and safety of the participant and the person-centered employment plan implementation through regular contacts at a minimum frequency as required by the department.

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

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

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

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

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

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

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

(Choose each that applies):

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

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

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:

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

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

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

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

☐	Participant-directed	X	Provider managed

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

Service Title: Career Exploration and Assessment

Service Definition (Scope):

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

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

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

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

An integral component of Career Assessment and Exploration is transportation which allows the participant to engage in opportunities such as job shadowing and community-based assessments.

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

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

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

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

(Choose each that applies):

X	Categorically needy *(specify limits)*:
	Career Exploration and Assessment may be authorized for up to 6 months in a benefit year, with multi-year service utilization and reauthorization only with explicit written Department approval. This service is not available to individuals who are eligible for or are receiving this benefit through vocational rehabilitation programs offered by the Division for the Visually Impaired (DVI). Federal Financial Participation (FFP) is not claimed for incentive payments, subsidies, or unrelated vocational training expenses.
☐	Medically needy *(specify limits)*:

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

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Career Exploration Agency	State Business License or 501 (c)(3) status	Pathways Certified Provider (utilizing DDDS Criteria)	Comply with all Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. Ensure employees complete Department-required training, including training on the participant's service plan and the participant's unique and/or disability-specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs. Individuals employed by providers must: • Have criminal background investigations in accordance with state requirements. • Have a screening against the child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del

			Code Section 708 and 11 Del Code Sections 8563 and 8564 and not have any adverse registry findings in the performance of the service. • Be state licensed (as applicable) or registered in their profession as required by state law. In the case of direct care personnel, possess certification through successful completion of training program as required by the Department.

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

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

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

☐	Participant-directed	X	Provider managed

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

Service Title:	Supported Employment-Individual

Service Definition (Scope):

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

Individual Supported Employment may also include support to establish or maintain self-employment, including home-based self-employment with business generated income for the participant. Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits support, training and planning, transportation, asset development and career advancement services, and other workplace support services including services not specifically related to job skill training that enable the participant to be successful in integrating into the job setting.

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

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

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

DDDS allows providers to offer Individual Supported Employment services either in person, by telephone, or virtually based upon the individual support needs of the service recipient.

If a service recipient chooses a virtual service modality for supported employment, in-person visits will not be required so long as the totality of the service recipient's employment support needs can be met virtually, otherwise it shall be a combination of virtual and in-person service delivery. Service recipients and/or guardians that express an interest in this service modality, will be supported to meet with the service recipient's team to discuss virtual options. If the service recipient and/or guardian choose this virtual modality for service delivery, and it is determined that it will meet the service recipient's needs, the service recipient's person-centered plan will be updated outlining the service recipient's and/or guardian's choice for virtual service delivery, as well as the specifics related to the scope, amount, frequency, and duration for both virtual and in-person service delivery. This virtual modality is optional for a service recipient and/or guardian to choose and will not be implemented if the service recipient and or guardian do not choose it. If it is determined by the support team that the service recipient's needs cannot be safely met through this service option, it will not be authorized.

This modality is not intended for service recipients that require physical or hands-on assistance, rather for service recipients that are functionally independent and require minimal assistance in order to complete tasks and remain employed. Services provided under this modality are decided by the service recipient and/or their guardian with their support team and is described in their person-centered plan as an acceptable means of service provision including that the service recipient has the technology necessary and the demonstrated ability to utilize the identified technology effectively as it relates to their desired goals or outcomes. This modality is intended to utilize a service recipient's already existing personal device(s) (cell phone, tablet, etc.) to communicate virtually. If a service recipient requires additional training to effectively utilize a particular device, or application on a device, the service provider will provide training and support before initiating virtual service delivery as well as assessing the service recipients level of comfort and ease of use in order to ensure the service recipient understands how the virtual conferencing service operates and that they can effectively navigate necessary steps to engage the service whether the service recipient or the provider is initiating the contact.

The device(s) used for this virtual service modality is not for remote monitoring purposes and are not designed to provide or augment personal care services or supports that may be needed. This virtual service modality is intended to use the service recipient's personal device(s) (cell phone, tablet, etc.) with the capability of supporting a video conferencing applications (Zoom, Skype, Teams, etc.) as a means for the job coach to check in and communicate with the service recipient. If the service

recipient does not have a device that supports virtual service delivery, they will be assisted with securing one that they can effectively use.

In events where the service recipient's device is not operational and the provider is unable to reach the service recipient for a scheduled contact, the provider will be required to meet the service recipient in-person to check in and to provide the service in-person.

Because this modality utilizes a service-recipient's personal device, they will have the ability to turn off their device whenever they so choose. If it is determined that the service recipient routinely turning off their device is impacting their employment due to the inability to provide services virtually, the team would meet with the service recipient/legal guardian to determine if virtual services delivery can continue with some adjustments or if the service needs to return to fully in-person.

The option of virtual service delivery for Supported Employment shall provide greater privacy than typical face to face services in the employment setting because the service recipient is not identified as being different from their non-disabled co-workers simply because there is a job coach on site with them. This also fosters a greater sense of independence and self-sufficiency by utilizing the most integrated and least restrictive type of support based upon the service recipients needs and preferences.

Virtual service delivery shall not be delivered in a way that compromises the service recipient's privacy.

By policy, no cameras or video-recording devices are to be placed in private areas, such as bedrooms, bathrooms, etc. The only time this is permitted is when the placement and utilization of such devices have been approved by the individual and/or guardian and has been reviewed and approved through the Human Rights Committee (HRC). The individual and/or guardian have the final authority related to their usage and implementation so long as the bathroom is not shared with any other service recipient(s), otherwise it is prohibited.

Providers supporting service recipients virtually are still mandated to report suspected incidents involving abuse, neglect, exploitation and financial exploitation as defined in Department of Health and Social Services (DHSS) Policy Memorandum #46.

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

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

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

(Choose each that applies):

X	Categorically needy *(specify limits)*:

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

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

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Supported Employment Agency	State Business License or 501 (c)(3) status	Pathways Certified Provider (utilizing DDDS Criteria)	Comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. Ensure employees complete Department-required training, including training on the participant's service plan and the participant's unique and/or disability-specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs. Individuals employed by providers must: • Have criminal background investigations in accordance with state requirements.

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

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

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

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

☐	Participant-directed	X	Provider managed

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

Service Title:	Supported Employment-Small Group

Service Definition (Scope):

Small Group Supported Employment are services and training activities provided in regular business, industry and community settings for groups of two (2) to no more than four (4) workers with disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Small Group Supported Employment must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces and be compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Small Group Supported Employment does not include vocational services provided in facility-based work settings, enclaves or other non-competitive or non-integrated job placements.

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

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

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

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

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

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

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

(Choose each that applies):

X	Categorically needy *(specify limits)*:

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

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

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Supported Employment agency	State Business License or 501 (c)(3) status	Pathways Certified Provider (utilizing DDDS Criteria)	Comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. Ensure employees complete Ensure employees complete Department-required training, including training on the participant's service plan

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

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

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

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

☐	Participant-directed	X	Provider managed

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

Service Title:	Benefits Counseling

Service Definition (Scope):

Benefits Counseling provides work incentive counseling services to Pathways to Employment participants seeking to work while maintaining access to necessary healthcare and other benefits. Benefits counseling will provide information to individuals regarding available benefits and assist participants to understand options for making an informed choice about going to work while maintaining essential benefits.

This service will assist participants to understand the work incentives and support programs available and the impact of work activity on those benefits. This service will assist participants to understand their benefits supports and how to utilize work incentives and other tools to assist them to achieve self-sufficiency through work.

This service will also include the development and maintenance of proper documentation of services, including creating Benefits Summaries and Analyses and Work Incentive Plans.

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

This service is in addition to information provided by the Aging and Disability Resource Centers (ADRC) or other entities providing information regarding long-term services and supports.

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

Delaware will ensure that individuals do not otherwise have access to this service through any other source, including SSA and WIPA.

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

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

(Choose each that applies):

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

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

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Benefits Counseling Agency	State Business License or 501 (c)(3) status		Comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications.

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

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

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

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

☐	Participant-directed	X	Provider managed

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

Service Title:	Financial Coaching Plus

Service Definition (Scope):

Financial Coaching Plus uses a financial coaching model to assist participants 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 participant seeking to improve his/her financial well-being in order to improve economic self-sufficiency. Financial Coaching Plus includes the development of a personal budget and identifies reliable and trusted savings, credit, and debt management 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 participant one-on-one in a setting convenient for the participant over a time-limited series of sessions and follow-up to increase the opportunity for self-directed behavior skills learning.

The Financial Coaching will:

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

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

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

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

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

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

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

(Choose each that applies):

X	Categorically needy *(specify limits)*:
	Financial Coaching Plus service limited to five hours per participant per year.
☐	Medically needy *(specify limits)*:

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

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Financial Coaching Agency	State Business License or 501 (c)(3) status	An agency must demonstrate that Financial Coaches who will provide this service are certified in the financial coaching curriculum developed by the Department of Health and Social Services and the University of Delaware Alfred Lerner College of Business and Economics and the Division of Professional Continuing Studies.	Comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications. The provider, including its parent company and its subsidiaries, and any sub provider, including its parent company and subsidiaries, agree to comply with the provisions of 29 Del Code Chapter 58, Laws Regulating the Conduct of Officers and Employees of the State and in particular with Section 5805 (d) Post Employment Restrictions. Ensure employees and/or contractors complete Department required training, including training on the participant's service plan and the participant's unique and/or disability specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs. Individuals employed or contracted by providers must: • Have criminal background investigations in accordance with state requirements. • Have a screening against the child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del Code Section 708 and 11 Del Code Sections 8563

			and 8564 and not have any adverse registry findings in the performance of the service. • Be state licensed (as applicable) or registered in their profession as required by state law. • In the case of direct care personnel, possess certification through successful completion of training program as required by the Department. An agency must demonstrate that Financial Coaches who will provide this service: • Have at least one year of full time financial coaching experience. • Are trained in Financial Coaching Plus strategies specific to the Pathways population.

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

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

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

☐	Participant-directed	X	Provider managed

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

Service Title:	Non-Medical Transportation

Service Definition (Scope):

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

Non-medical Transportation services are offered, in addition to any medical transportation furnished under the 42 CFR 440.17(a) in the State Plan. Non-medical Transportation services are necessary, as specified by the person-centered employment plan to enable individuals to gain access to employment services. In order to be approved, non-medical transportation would need to be directly related to a goal on the participant's person-centered employment plan (e.g., to a supported employment site) 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 participant's needs as determined by an assessment performed in accordance with Department requirements and as specifically outlined in the participant's person-centered employment plan.

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

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

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

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

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

(Choose each that applies):

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

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

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Transportation Broker Agency ***The providers of this service will be limited per***	State Business License or 501 (c)(3) status	Broker	All drivers possess a valid driver's license. All vehicles are properly registered and insured.

concurrent operation with the Pathways 1915(b)(4) waiver of free choice of providers for this service, necessary to ensure conflict free status, access and quality.			

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

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

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

☐	Participant-directed	X	Provider managed

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

Service Title:	Personal Care

Service Definition (Scope):

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

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

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

Personal Care may include escorting participants to the workplace.

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

communication needs.	
Additional needs-based criteria for receiving the service, if applicable *(specify)*:	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies)*:	
X	Categorically needy *(specify limits)*:
	This service is over and above that which is available to the individual through the State Plan EPSDT benefit, the DSHP Plus program, or any other Delaware HCBS waiver, as applicable.
☐	Medically needy *(specify limits)*:

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

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

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

			accordance with 19 Del Code Section 708 and 11 Del Code Sections 8563 and 8564 and not have any adverse registry findings in the performance of the service. • Be legally able to work in the state of Delaware. • Must complete training through Support for Participant Direction vendor within 90 days of enrollment as a provider. (Exceptions to the training requirement are made by the Support for Participant Direction vendor on a case-by-case basis for emergency back-up providers.)

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

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

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

☒	Participant-directed	X	Provider managed

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

Service Title:	Orientation, Mobility, and Assistive Technology

Service Definition (Scope):

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

(A) the evaluation and assessment of the assistive technology needs of a participant, including a

functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;

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

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

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

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

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

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

Orientation and Mobility

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

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

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

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

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

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

(Choose each that applies):

X	Categorically needy *(specify limits)*:

	These assessments, items or services must not otherwise be available to participants under the DSHP. Assistive Technology devices must be obtained at the lowest cost. The amount of this service for Assistive Technology devices is limited to $10,000 for the participant's lifetime. This amount includes replacement parts and repair when it is more cost effective than purchasing a new device. Exceptions to this limit may be considered based upon a needs assessment and prior authorization by the Department.
☐	Medically needy *(specify limits)*:

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

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Certified Orientation and Mobility Specialist	n/a	COMS	Meet minimum standards as set forth by Department of Vocational Rehabilitation or Division for the Visually Impaired as applicable for comparable services.
Certified Vision Rehabilitation Therapist	n/a	CVRT	Meet minimum standards as set forth by Department of Vocational Rehabilitation or Division for the Visually Impaired as applicable for comparable services.
Occupational Therapist	OTR/L	AOTA SCEM	Meet minimum standards as set forth by Department of Vocational Rehabilitation or Division for the Visually Impaired as applicable for comparable services.
Assistive Technology Professional	n/a	ATP RESNA Rehabilitation Engineering and Assistive Technology Society of North America	Meet minimum standards as set forth by Department of Vocational Rehabilitation or Division for the Visually Impaired as applicable for comparable services.
Low Vision Therapist	n/a	LVT - Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP)	Meet minimum standards as set forth by Department of Vocational Rehabilitation or Division for the Visually Impaired as applicable for comparable services.
Durable Medical	State Business		

Equipment Suppliers	License or 501 (c)(3) status		
Assistive Technology Suppliers	State Business License or 501 (c)(3) status		

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

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

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

☐	Participant-directed	X	Provider managed

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

(a) DDDS allows relatives to become qualified to provide Personal Care for service recipients. Guardians of participants may be paid to provide personal care services under the self-directed option, as it applies to supporting the service recipient's employment related goals and only if approved by an Employment Navigator. The participant's Employment Navigator is instrumental in ensuring that services are appropriate for each service recipient.

(b) Payment is authorized for relatives to provide only those personal care services designated in the person-centered employment plan, which respond to a specific deficit or deficits in a participant's capacity to carry out ADLs and/or IADLs and which represent extraordinary care not typically provided by relatives in the absence of these deficits. The service plan includes authorization for service hours that include only those services and supports not ordinarily provided by a relative in the absence of ADL and/or IADL deficits, including such supports as health maintenance activities; bathing and personal hygiene; bowel or urinary evacuation; and feeding. Activities which might, in the absence of ADL and/or IADL deficits, be considered shared responsibilities of relatives who are members of a household, such as shopping, cleaning, or bill payment, are not considered for

reimbursement for personal care attendants under the Pathways program, except under unusual circumstances and at the discretion of the Employment Navigator.

(c) The Employment Navigator will administer a standardized risk assessment tool that includes screening questions to determine the appropriateness of the family member/legal guardian as the caregiver for an individual. The screening tool includes such questions as:

- Does having a family member/legal guardian as a direct support staff expand the individual's support circle or risk diminishing it?
- Is this about the service recipient's wishes, desires, and needs or about supplementing a family member's income?
- Does this family member create a barrier to increased community integration or friendship development, acquiring and maintaining competitive employment, etc.?

Based on the results of the assessment, the Employment Navigator will make a recommendation to DDDS regarding whether the guardian should be allowed to be the self-directed caregiver. The state will make the final decision. If the Employment Navigator believes that the guardian as caregiver will not be in the best interest of the service recipient, as a result of the screening process, the case must be reviewed by the DDDS Director of Community Services who will make a final decision.

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

(d) When a guardian is paid as the caregiver under the self-directed option, in order to ensure the safety of the service recipient, DDDS instructs the Employment Navigator to locate a third party who can represent the service recipient and supervise the provider, including signing their timesheet, when the service recipient is unable to do so. In these cases, the third party representative will be the joint employer with the Agency with Choice (AWC) Broker. When a parent guardian who is the self-directed caregiver of a service recipient is not the sole guardian, the other guardian may be designated as the representative. Relatives and guardians must meet any applicable provider standards and training requirements in order to be a paid provider.

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

(e) The AWC Broker will ensure that the relative/guardian caregiver meets the requirements before a paid service is rendered. Utilization will be monitored by the Employment Navigator against the plan to ensure that services are provided for the benefit of and in the best interest of the individual.

Because the AWC Broker will be serving as the employee of record, it will submit and be paid for claims for self-directed services in the same manner as other fee-for-service Medicaid claims. The DDDS Pathways Administrator will be responsible for monitoring claims paid to the AWC Broker as the provider. The DDDS Pathways Administrator will be responsible for ensuring that the AWC

provider claims match what was paid to the employee.

In addition to monitoring claims submitted by the AWC Broker, DDDS will also monitor performance against contractual requirements. Such requirements will include maintenance of documentation to comply with IRS and US DOL requirements such as: provider screening and training, copy of IRS Forms W-4 and I-9, accuracy of wage payments and withholdings, payment of overtime and travel, as required.

Quarterly, the DDDS Pathways Administrator will verify AWC Broker payment/filing of the State Income Tax, Unemployment Tax, Workers Compensation and IRS Forms 940 and 941 and Forms W-2/W-3.

Annually, DDDS will also review the AWC Broker's standard operating procedures and required reporting on performance metrics such as timeliness of payroll and payment of other invoices by the AWC Broker, participant satisfaction, and timeliness of response to customer calls where a message is left after hours, compliant resolution, etc. as specifies in the contract.

(f) For relatives and/or guardian caregivers, the Employment Navigator will document within the plan how the person is qualified to meet the needs of the service recipient. A strong person-centered focus in the initial planning process is critical to ensuring that the care provided by relatives or guardians is in the best interest of the service recipient. This process lays the groundwork for assuring that the individual's opportunities for independence and exercising choice and control over his or her own life are preserved. It is the responsibility of the Employment Navigator to ensure that the voice of the service recipient is heard and that the individual is supported to be a self-advocate in the planning process to ensure that the use of relatives or guardians is the preferred path. DDDS requires Employment Navigators to be trained in conflict resolution techniques in the event that a situation arises in the provision of care by a relative or guardian that must be resolved.

Participant-Direction of Services

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

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

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

2. Description of Participant-Direction. (Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how

participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):

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

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

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

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

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

X	Participant direction is available in all geographic areas in which State plan HCBS are available.
O	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option):*

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

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

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

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

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

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

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

Voluntary Termination of Participant Direction

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

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

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

Involuntary Termination of Participant Direction

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

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

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

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

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

8. Opportunities for Participant-Direction

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

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

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

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

Quality Improvement Strategy

Quality Measures

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

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

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

3. **Providers meet required qualifications.**

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

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

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

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

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

Requirement	Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.
Discovery	
Discovery Evidence *(Performance Measure)*	Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers. 1. The number and percentage of participants that report that they helped develop their employment plan. (Numerator: The number of participants documented as participating in the development of their employment plan. Denominator: The number of participants whose plans were reviewed) 2. Number and percent of participants with employment plans consistent with their individual assessments. (Numerator: The number of participants whose employment plans are consistent with their Lifelong Career Assessment Matrix (LCAM). Denominator: The number of participants whose plans were reviewed)

		3. The percentage of participants whose service plan contains documentation that the participant was supported to make an informed choice about their providers(s). (Numerator: The number of participants whose service plans contain documentation that the participant was supported to make an informed choice about their provider(s). Denominator: Total number of participants whose plans were reviewed.) 4. The percentage of participants whose service plan was updated prior to the annual plan date. (Numerator: The number of participants whose employment plans are updated prior to the annual plan date. Denominator: The total number of participants whose plans were reviewed).
	Discovery Activity *(Source of Data & sample size)*	1. Record Review. Representative Sample; Confidence Interval = 95% 2. Record Review. Representative Sample; Confidence Interval = 95% 3. Record review. Representative Sample; Confidence Interval = 95% 4. Record Review. Representative Sample, Confidence Interval = 95%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDDS
	Frequency	Continuously and Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The operating division will serve an active role in correcting identified problems. The division will aggregate and analyze the data for the program, and will utilize the Pathways Workgroup, which includes DMMA to lead program remediation strategies. Delaware will collect data to establish a benchmark against which future improvement will be measured. Remediation is expected upon detection of issue. Issues are initially discussed among involved parties so as to clearly communicate findings and desired outcomes, followed by a written report reiterating those areas and the date by which issues must be resolved.
	Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement	Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
Discovery	
Discovery Evidence *(Performance Measure)*	1. The percentage of new Pathways participants who met eligibility criteria that were enrolled during the period prior to the initiation of Pathways services. (Numerator: The total number of new participants enrolled during the period who met the eligibility criteria prior to the initiation of Pathways services. Denominator: Total number of participants enrolled during the review period.) 2. The percentage of new Pathways participants that met initial eligibility during the period when the eligibility criteria was applied correctly. (Numerator: The total number of new participants that met initial eligibility during the period when eligibility criteria was applied correctly. Denominator: Total number of new participants who were enrolled during the period reviewed.) 3. The percentage of Pathways participants whose eligibility was reevaluated at a minimum of annually. (Numerator: The total number of participants whose eligibility was reevaluated at a minimum of annually. Denominator: Total number of participants enrolled in the program.)
Discovery Activity *(Source of Data & sample size)*	100% Record Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDDS
Frequency	Continuously and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The operating division will serve an active role in correcting identified problems. The division will aggregate and analyze the data for the program, and will utilize the Pathways Workgroup, which includes DMMA to lead program remediation strategies. Remediation is expected upon detection of issue. Issues are initially discussed among involved parties so as to clearly communicate findings and desired outcomes, followed by a written report reiterating those areas and the date by which issues must be resolved.
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

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

Requirement	Settings meet the home and community-based settings requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (a)(2)
Discovery	
Discovery Evidence *(Performance Measure)*	1. The percentage of Pathways participants that are residing in settings that comply with HCBS setting requirements. (Numerator: The total number of participants that reside in settings that comply with HCBS settings requirements. Denominator: Total number of participants enrolled in the program.) 2. The percentage of Pathways participants receiving Pathways services in settings

		that comply with HCBS settings requirements. (Numerator: The total number of participants receiving Pathways services in settings that comply with HCB settings requirements. Denominator: Total number or participants enrolled in the program.)
	Discovery Activity *(Source of Data & sample size)*	1. Record Review. Representative Sample; Confidence Interval = 95%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDDS
	Frequency	Continuously and Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	1. Employment Navigators in the operating divisions will regularly monitor the settings in which participants reside. Anyone found to no longer reside in an HCBS setting will be dis-enrolled from the program. 2. Employment Navigators will regularly monitor the settings in which participants receive Pathways services. Non-compliant HCB Settings will no longer be allowed as setting sites.
	Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement		The SMA retains authority and responsibility for program operations and oversight
Discovery		
	Discovery Evidence *(Performance Measure)*	1. Percent of needs-based eligibility assessments where the decision of the reviewer was validated by DMMA. (Numerator: Number of needs-based eligibility assessments where the decision of the reviewer was validated by DMMA. Denominator: The total number of needs-based eligibility assessments reviewed.) 2. Number and percent of performance reports reviewed by the DMMA (Numerator: Number of performance reports reviewed by DMMA and determined to be compliant. Denominator: Total number of performance reports reviewed). 3. Percent of DMMA's quarterly performance review meetings during which PTE quality assurance and improvement are discussed (Numerator: Number of DMMA's quarterly meetings during which PTE QA/I are discussed. Denominator:

	Total number of quarterly DMMA performance review meetings.)
Discovery Activity *(Source of Data & sample size)*	1. Record Review. Representative Sample; Confidence Interval = 95% 2. Administrative Records Representative Sample; Confidence Interval = 95% 3. Administrative records. Representative Sample; Confidence Interval = 95%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMMA
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The operating divisions will serve an active role in correcting identified problems, with DMMA providing oversight.
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
Discovery	
Discovery Evidence *(Performance Measure)*	1. Number and percent of rates adhering to reimbursement methodology in the approved State plan amendment. (Numerator: Number of rates adhering to approved reimbursement methodology. Denominator: Total number of established rates.) 2. Number and percent of employment plans where services were delivered in accordance with service plan with regard to duration/frequency. (Numerator: Number of employment plans where services were delivered in accordance with the employment plan in regard to duration/frequency. Denominator: Total number of employment plans reviewed.) 3. Percentage of paid claims which are prior-authorized and furnished by qualified

	providers. (Numerator: The number of paid claims that are authorized and furnished by qualified providers. Denominator: The total number of paid claims during the review period.)
Discovery Activity *(Source of Data & sample size)*	1. Administrative Data and Record Review Representative Sample; Confidence Interval = 95% 2. Administrative data; Record Review Representative Sample; Confidence Interval = 95%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMMA and DDDS
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The operating divisions will serve an active role in correcting identified problems. The divisions will aggregate and analyze the data and will utilize the Pathways Workgroup (which includes each operating division and DMMA) to lead cross-program remediation strategies. Remediation is expected upon detection of issue. Issues are initially discussed among involved parties so as to clearly communicate findings and desired outcomes, followed by a written report reiterating those areas and the date by which issues must be resolved. Pathways Administrators monitor utilization against the prior authorization on a quarterly basis. There is a thorough review of provider service documentation and provider utilization of authorized billing units. Unusual changes or noted discrepancies are reported to the provider in writing, and the provider is required to conduct an internal audit, report on corrective actions, provide clear strategies to prevent future incidences, and provide documented evidence that arrangements have been made with DMMA's fiscal agent for recoupment of any funds received inappropriately. In addition, the DDDS Service Integrity and Enhancement Unit and the DDDS Office of Business Supports and Services are also responsible for on-going provider management and detection of inappropriate billing via routine monitoring and auditing activities including daily service documentation during the Quality Service Review (QSR) and monthly service utilization reports.
Frequency *(of Analysis and Aggregation)*	Quarterly and Annually

Requirement	The State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

Discovery		
	Discovery Evidence *(Performance Measure)*	1. The percentage of incidents of Abuse/Neglect/Mistreatment that were reported in accordance with Pathways requirements. (Numerator: Total number of incidents of Abuse/Neglect/Mistreatment involving PTE participants that were reported in accordance with Pathways requirements. Denominator: Total number of incidents involving PTE participants that were reported.) 2. The percentage of incidents of Abuse/Neglect/Mistreatment/Unexplained Death that occurs in a provider managed setting by type in which follow-up was completed in accordance with applicable Department requirements. (Numerator: Total number of incidents of Abuse/Neglect/Mistreatment/Unexplained Death involving PTE participants by type where follow up was completed in accordance with applicable Department requirements. Denominator: Total number of incidents involving PTE participants that were reported.) 3. The percentage of employed participants reporting that they feel safe at work. (Numerator: The number of participants reporting that feel safe at work. Denominator: Total number of participants enrolled in the program) 4. The percentage of reported incidents of emergency restrictive behavior intervention strategies implemented according to protocol per DDDS Use of Restraints and Restrictive Procedures for Behavior Support Policy. (Numerator: The number of reported incidents of emergency restrictive behavior intervention strategies involving PTE participants that were implemented according to protocol per DDDS Behavioral and/or Mental Health Support Policy. Denominator: Total number of reported incidents of emergency restrictive behavior strategies involving PTE participants during the reporting period)
	Discovery Activity *(Source of Data & sample size)*	1. Record Review. Representative Sample; Confidence Interval = 95% 2. Record Review. Representative Sample; Confidence Interval = 95% 3. Participant Questionnaire. Representative Sample; Confidence Interval = 95% 4. Representative Sample; Confidence Interval = 95%.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DDDS
	Frequency	Continuously and Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The operating divisions will serve an active role in correcting identified problems. The divisions will aggregate and analyze the data and will utilize the Pathways Workgroup (which includes each operating division and DMMA) to lead cross-program remediation strategies. Remediation is expected upon detection of issue. Issues are initially discussed among involved parties so as to clearly communicate findings and desired outcomes, followed by a written report reiterating those areas and the date by which issues must be resolved.
	Frequency *(of Analysis and*	Quarterly and Annually

	Aggregation)	

System Improvement

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

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

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

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

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

2. **Roles and Responsibilities**

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

3. **Frequency**

Continuously and ongoing

4. **Method for Evaluating Effectiveness of System Changes**

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

Methods and Standards for Establishing Payment Rates

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

X	HCBS Case Management
	The Employment Navigation rate is computed from annual provider costs from the prior period. The following list outlines the major allowable cost components used in rate development using federally accepted cost principles (2 CFR 200 cost principles). • Staffing Assumptions and Staff Wages • Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation) • Staff Productivity Assumptions (e.g., time spent on billable activities) • Program-Related Expenses (e.g., technology related expenses, supplies) • Provider Overhead Expenses Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of case management. The agency's fee schedule rate was set as of 7/1/2024 and is effective for services provided on and after that date. All rates are published on DDDS's website at the following address: DDDS Waiver and Pathways Provider Rates - Delaware Health and Social Services - State of Delaware
☐	HCBS Homemaker
☐	HCBS Home Health Aide
X	HCBS Personal Care
	Personal care rates are computed depending on the type of Pathways provider delivering Personal Care as follows: Home Health Agency Rate: As established under attachment 4.19-B of the Delaware State Plan for Medical Assistance, page 6 for an HH Aide. Personal Care Agency Rate: 75% of the Medicaid rate for HHAs for an aide. This percentage was derived by comparing usual and customary hourly rates for aide services delivered through HHAs as opposed to PASA agencies and establishing the relationship between the rates. Participant-directed Rate: The fiscal intermediary will establish the rate with input from the waiver member. The fiscal intermediary will ensure that all rates and payments comply with the US DOL Fair Labor Standards Act and that all applicable federal and state payroll taxes are paid.

	All rates are published on DDDS's website at the following address: DDDS Waiver and Pathways Provider Rates - Delaware Health and Social Services - State of Delaware
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☐	HCBS Respite Care
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
X	Other Services (specify below)
	Career Exploration and Assessment The rate for Career Exploration and Assessment was calculated using a market basket methodology. • Staffing Assumptions and Staff Wages • Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation) • Staff Productivity Assumptions (e.g., time spent on billable activities) • Program Indirect Expenses (e.g., supplies) • Provider Overhead Expenses Wage data was obtained from authoritative sources such as the U.S. DOL Bureau of Labor Statistics for job classifications with similar requirements and duties as the direct support professionals performing this service in order to derive an appropriate DSP hourly wage rate. In developing the other rate components, provider cost data for the allowable costs included in the "market basket" was collected. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Career Exploration and Assessment. The agency's fee schedule rate was set as of 7/1/2024 and is effective for services provided on and after that date. All rates are published on DDDS's website at the following address: DDDS Waiver and Pathways Provider Rates - Delaware Health and Social Services - State of Delaware.

Supported Employment – Individual

The methodology and rate for Individual Supported Employment is the same as those computed under Delaware's Lifespan 1915(c) waiver (DE 0009). The Individual Supported Employment rate was calculated using a market basket methodology. This rate methodology is comprised of the following key components:

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

Wage data was obtained from authoritative sources such as the U.S. DOL Bureau of Labor Statistics for job classifications with similar requirements and duties as the direct support professionals performing this service in order to derive an appropriate DSP hourly wage rate. In developing the other rate components, provider cost data for the allowable costs included in the "market basket" was collected. These costs are converted to percentages that are multiplied by the direct support hourly wage rate as a set of recursive percentages in order to develop an hourly provider DSP rate.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Supported Employment. The agency's fee schedule rate was set as of 7/1/2024 and is effective for services provided on and after that date. All rates are published on DDDS's website at the following address:
DDDS Waiver and Pathways Provider Rates - Delaware Health and Social Services - State of Delaware

Supported Employment - Small Group

Rates for Small Group Supported Employment are the same as those computed under Delaware's Lifespan 1915(c) waiver (DE 0009). Small Group Supported Employment rates were calculated using a market basket methodology. This rate methodology is comprised of the following key components:

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

Wage data was obtained from authoritative sources such as the U.S. DOL Bureau of Labor

	Statistics for job classifications with similar requirements and duties as the direct support professionals performing this service in order to derive an appropriate DSP hourly wage rate. In developing the other rate components, provider cost data for the allowable costs included in the "market basket" was collected. These costs are converted to percentages that are multiplied by the direct support hourly wage rate as a set of recursive percentages in order to develop an hourly provider DSP rate. A separate rate is established for each group size, up to 4 HCBS recipients, by dividing by the base rate by the number of individuals in the group. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Supported Employment. The agency's fee schedule rate was set as of 7/1/2024 and is effective for services provided on and after that date. All rates are published on DDDS's website at the following address: DDDS Waiver and Pathways Provider Rates - Delaware Health and Social Services - State of Delaware
	Non-Medical Transportation Non-Medical transportation will be implemented utilizing a transportation broker. The state will pay the broker on a fee-for-service basis with administrative compensation for the coordination and delivery of transportation. The rates will be one of the following, depending on the most direct, cost effective mode of transport: - Per mile (using established state reimbursement per mile) - Per public transportation trip using fees established by public transportation agency(ies) - Per trip, using a methodology based upon average miles per trip, number of individuals in transport and any specialized mode of transportation required.
	Benefits Counseling The rate for Benefits Counseling was calculated using a market basket methodology. This rate methodology is comprised of the following key components: • Staffing Assumptions and Staff Wages • Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation) • Staff Productivity Assumptions (e.g., time spent on billable activities) • Program Indirect Expenses (e.g., supplies) • Provider Overhead Expenses Wage data was obtained from authoritative sources such as the U.S. DOL Bureau of Labor Statistics for job classifications with similar requirements and duties as the direct support professionals performing this service in order to derive an appropriate DSP hourly wage rate. In developing the other rate components, provider cost data for the allowable costs included in the "market basket" was collected. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both

governmental and private providers of Supported Employment. The agency's fee schedule rate was set as of 7/1/2024 and is effective for services provided on and after that date. All rates are published on DDDS's website at the following address:
DDDS Waiver and Pathways Provider Rates - Delaware Health and Social Services - State of Delaware

Financial Coaching Plus

The rate for Financial Coaching Plus was calculated using a market basket methodology. This rate methodology is comprised of the following key components:

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

Wage data was obtained from authoritative sources such as the U.S. DOL Bureau of Labor Statistics for job classifications with similar requirements and duties as the direct support professionals performing this service in order to derive an appropriate DSP hourly wage rate. In developing the other rate components, provider cost data for the allowable costs included in the "market basket" was collected.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Financial Coaching. The agency's fee schedule rate was set as of 7/1/2024 and is effective for services provided on and after that date. All rates are published on DDDS's website at the following address:
DDDS Waiver and Pathways Provider Rates - Delaware Health and Social Services - State of Delaware

Orientation, Mobility, and Assistive Technology

The methodology and rates for Assistive Technology assessment and training are the same as those computed under Delaware's Lifespan 1915(c) waiver (DE 0009).

The rate for these services were calculated using a market basket methodology. This rate methodology is comprised of the following key components:

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

Wage data was obtained from authoritative sources such as the U.S. DOL Bureau of Labor Statistics for job classifications with similar requirements and duties as the direct support professionals performing this service in order to derive an appropriate DSP hourly wage rate. In developing the other rate components, provider cost data for the allowable costs included in the "market basket" was collected.

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

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Orientation, Mobility, and Assistive Technology. The agency's fee schedule rate was set as of 7/1/2024 and is effective for services provided on and after that date. All rates are published on DDDS's website at the following address: DDDS Waiver and Pathways Provider Rates - Delaware Health and Social Services - State of Delaware