Table of Contents

State Name: Delaware

State Plan Amendment (SPA) #18-001

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS-179
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
801 Market Street
Suite 9400
Philadelphia, PA 19107-3134

Region III/Division of Medicaid and Children's Health Operations

SWIFT #051020184027

June 22, 2018

Mr. Stephen M. Groff, Director
Division of Medicaid and Medical Assistance
P.O. Box 906
New Castle, DE 19720-0906

Dear Mr. Groff:

We are pleased to inform you of the approval of Delaware State Plan Amendment (SPA) 18-001. This amendment modifies the State Plan to establish coverage for targeted case management services for children and youth with serious emotional disturbance, mental health or substance use disorder or co-occurring mental health and substance use disorders meeting Department of Services to Children Youth and Their Families (DSCYF), Division of Prevention and Behavioral Health Services (DPBHS) eligibility criteria. Enclosed is a copy of the approved SPA pages and the signed CMS-179 form. The effective date of this amendment is April 1, 2018.

If you have any questions, you may contact Michael Cleary at (215) 861-4282.

Sincerely,

[redacted]

Francis T. McCullough
Associate Regional Administrator

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **SPA # 18-001**

2. STATE: **DELAWARE**

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN **XXX** AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

- **42 CFR §447.201**
- **42 CFR §447.205**
- **42 CFR §441.18**
- **42 CFR §447.205**
- **§1903(c) of the Social Security Act**
- **§1915(g)(1) of the Social Security Act**
- **§1902(a)(23) of the Social Security Act**
- **§1902(a)(25) of the Social Security Act**

7. FEDERAL BUDGET IMPACT:
a. FFY 2018 $ 73,430
b. FFY 2019 $ 293,720

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
4.19-B Page 29
Sppl 5 to Attach 3.1-A Page 1-6

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
N/A
N/A

10. SUBJECT OF AMENDMENT: **Targeted Case Management for Children and Youth with Serious Emotional Disturbance**

11. 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
XXX OTHER, AS SPECIFIED:
Governor's comments under separate correspondence

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Stephen M. Groff, Director, Division of Medicaid and Medical Assistance

14. TITLE: **Designee for Kara Odom Walker, MD, MPH, MSHS, Secretary, Delaware Health and Social Services**

15. DATE SUBMITTED:

16. RETURN TO:
Stephen M. Groff
Director
Division of Medicaid and Medical Assistance
P.O. Box 906
New Castle, Delaware 19720-0906

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
April 6, 2018

18. DATE APPROVED:
June 21, 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
April 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Francis McCullough

22. TITLE:
Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

https://www.macpac.gov/wp-content/uploads/2018/03/Telehealth-in-Medicaid.pdf
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: **DELAWARE**

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Children and Youth with Serious Emotional Disturbance, or Co-occurring Mental Health and Substance Use Disorders meeting DPBHS Eligibility Criteria

Reimbursements for services are based upon a Medicaid fee schedule established by the Delaware Medical Assistance Program (DMAP).

The fee development methodology built fees considering each component of provider costs as outlined below. These reimbursement methodologies produced rates sufficient to enlist enough providers so that services under the State Plan are available to beneficiaries at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act and 42 CFR 447.200, regarding payments and are consistent with economy, efficiency, and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule is equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule.

The fee development methodology will primarily be composed of provider cost modeling, through Delaware provider compensation studies, cost data, and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in fee development:

- Staffing Assumptions and Staff Wages;
- Employee-Related Expenses – Benefits, Employer Taxes (e.g., Federal Insurance Contributions Act (FICA), unemployment, and workers compensation)**;**
- Program-Related Expenses (e.g., supplies)**;**
- Practice model standards *(Compensation, supervision, materials and supplies, travel, training, administration, and utilization);*
- Provider Overhead Expenses; and
- Program Billable Units.

The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units. A unit of service is defined according to Healthcare Common Procedure Coding System (HCPCS) approved code set unless otherwise specified.

Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both governmental and private individual providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the Delaware Register of Regulations.
The Agency's fee schedule rate was set as of April 1, 2018 and is effective for services provided on or after that date. All rates are published on the Delaware Medical Assistance Program (DMAP) website at http://www.dmap.state.de.us/downloads/feeschedules.html.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: **DELAWARE**

TARGETED CASE MANAGEMENT SERVICES FOR

Children and Youth with Serious Emotional Disturbance, or Co-occurring Mental Health and Substance Use Disorders meeting DPBHS Eligibility Criteria

A. Target Group:
   1. Meets the eligibility criteria for services provided by the Division of Prevention and Behavioral Health Services (DPBHS);
   2. Is in a federal eligibility category for Delaware Medical Assistance, which governs the determination of eligibility for Delaware Medical Assistance Program. Services shall be provided to children and adolescents eligible for DPBHS services under 21 years of age diagnosed with a serious emotional disturbance, mental health or substance use disorder, or co-occurring mental health and substance use disorders, according to the current Diagnostic and Statistical Manual of the American Psychiatric Association until they age out of care.
   3. Meets at least two of the following conditions:
      a. Is not linked to behavioral health, health insurance, or medical services;
      b. Lacks basic supports for education, income, shelter, and food;
      c. Needs care coordination services to obtain and maintain community-based treatment and services; or
      d. Is receiving services through DPBHS.
   4. ☒ Target group includes individuals currently living in the community or individuals transitioning to a community setting. Regarding individuals transitioning, targeted case management services will be made available for up to 60 consecutive days of covered stay in an inpatient medical institution (the Medicaid certified facility in which the recipient is currently residing). The target group does not include individuals between ages 22 and 64 who are serviced in institution for Mental Disease or individuals who are inmates of public institutions (State Medicaid Directors Letter (SMDL), July 25, 2000).

B. Areas of State in which services will be provided:

   ☒ Entire State.

   ☐ Only in the following geographic areas (authority of section 1915(g)(1) of Act is invoked to provide services less than Statewide:

C. Comparability of Services:

   ☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

   ☒ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:
Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services, which includes responsibility for locating, coordinating and monitoring appropriate services for an individual. Targeted Case Management includes the following:

1. Comprehensive Assessment and Periodic Reassessment of individual needs, to determine the need for any medical, educational, social, or other services. These assessment activities include:
    - Taking client history;
    - Identifying the individual' s needs and strengths and completing related documentation; and
    - Gathering and reviewing documentation/information from other sources such as family members, medical providers, social workers, and educators (if necessary), need to form a complete and comprehensive assessment of the eligible individual.

    The Targeted Case Manager will use a child and youth assessment tool designated by the Department or its designee to:
    - Complete the initial assessment and to reassess at a minimum of every 3 months;
    - Record information that may relate to the individual's mental health, social, familial, educational, cultural, medical, and other areas to evaluate the extent and nature of the individual needs and strengths and assist in the development of the Plan of Care (POC); and
    - Coordinate and facilitate child and family team meetings (e.g., family members, friends, caretakers, providers, educators, and others, as appropriate) that:
        - Identify a team meeting location that is suitable for the child and family's needs;
        - Convene at least once every 3 months, or more frequently, as clinically necessary or indicated in the Plan of Care.
        - Targeted Case Managers providing certified Wraparound will convene child and family team meetings monthly or more frequently, if needed.

2. Development (and periodic revision) of the Plan of Care based on the information obtained through the initial comprehensive assessment that includes the following:
    - Developed and updated through the Child and Family Team meeting process;
    - Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual;
    - Include a crises plan including the proposed strategies and interventions for preventing and responding to crises and the youth and family's definition of what constitutes a crises;
    - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
    - Identifies a course of action to respond to the assessed needs of the individual.

3. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, education providers or other programs, services

and supports that are capable of providing needed services and supports to address identified needs and achieve goals in the care plan).

4. Monitoring and follow-up activities, including activities and contacts as necessary to ensure that the Plan of Care is effectively implemented and adequately addresses the needs of the eligible individual and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including regular (at least one annually) monitoring to:
   - Determine whether the following conditions are met:
     - Services are being furnished in accordance with the individual's Plan of Care;
     - Services in the care plan are adequate;
     - There are changes in the needs or status of the eligible individual are reflected in the Plan of Care. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
   - Complete a periodic review of the progress that the individual has made on the Plan of Care goals and objective and the appropriateness and effectiveness of services being provided;
   - Provide ongoing follow up on service referrals and monitoring of service provision to ensure that the agreed upon services are provided, meet the individual's needs and goals, and ensure the quality, quantity, and effectiveness of services are appropriate and in accordance with the Plan of Care; and
   - Revise, continue, or terminate of the Plan of Care, if no longer appropriate.

   ☒ Targeted case management includes contacts with non-eligible individuals who are directly related to identifying the individual's needs and care, for the purposes of helping the eligible individual access services, identify needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs 42 CFR §440.169(e).

E. Qualification of Providers:

A targeted case manager must be employed by DSCYF or a targeted case manager provider agency contracting with DSCYF. A targeted case manager must meet the following criteria:

- Bachelor's degree or higher in Behavioral or Social Science or related field;
- Certification in the State of Delaware to provide the service, which includes criminal and professional background checks, and completion of state-required training in wraparound philosophy and policies within six months of employment;
- Maintain certification through state approved continuing education/professional development annually;
- Six months experience in case management which includes assessing, planning, developing, implementing, monitoring, and evaluating options and services to meet an individual's needs;
- Six months 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 month experience in interpreting laws, rules, regulations, standards, policies and procedures; and

- Six months experience in narrative report writing.

A highly qualified targeted case manager must be employed by DSCYF or a targeted case manager provider agency contracting with DSCYF. A targeted case manager must meet the following criteria:

- Bachelor's degree, Master's degree preferred, in social work, psychology, counseling, nursing, occupational therapy, vocation rehabilitation, therapeutic recreation, or human resources and two years of experience working with special population groups in a direct care setting or a master's degree in one of the fields listed above;
- Successful completion of the approved wraparound certification training, or be classified as "provisionally certified," which means one must successfully complete the Wraparound Certification training within nine months of beginning to provide case management;
- Maintain wraparound certification status by attending an approved wraparound recertification training at least once every two years;
- Basic knowledge of behavior management techniques;
- Skill in interviewing to gather data and complete needs and strengths assessment in preparation of narratives/reports, in development of service plans, and in individual and group communication;
- Knowledge of state and federal requirements related to behavioral health; and
- Ability to use community resources.

A Targeted Case Management Provider Agency must have:

- A contract with the State of Delaware with requisite expertise in supporting individuals with serious emotional disturbance, substance use disorder or co-occurring disorder and their families;
- Demonstrated ability to coordinate and link community resources required through at least three years of prior experience;
- At least three years of experience with the targeted group;
- Sufficient staff and/or agreements with community organizations to have the administrative capacity to ensure quality of services in accordance with state and federal requirements;
- A financial management system which provides documentation of services and costs;
- Capacity to document and maintain individual case records in accordance with state and federal requirements;
- Demonstrated ability to assure referrals consistent with section 1902(a)(23), freedom of choice of providers;
- Ability to provide linkage with other case managers to avoid duplication of case management services;
- Ability to determine that the client is included in the target group; and
- Ability to access systems to track the provision of services to the client.

F. Freedom of Choice 42 CFR §441.18(a)(1)

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

G. Freedom of Choice Exception §1915(q)(1) and 42 CFR 441.18(b):

☒ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services: *[Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]*

The State will limit providers of targeted case management to the Department of Services for Children, Youth and Their Families (DSCYF). DSCYF may sub-contract for this service. This limitation is in compliance with Section 4302.2, paragraph D. of the State Medicaid Manual.

H. Access to Services 42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):

The State assures the following:

a. Targeted case management services will not be used to restrict an individual's access to other services under the plan;
b. Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition of receipt of other Medicaid services on receipt of targeted case management services; and
c. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

I. Payment 42 CFR 441.18(a)(4)

Payment for targeted case management services under the Medicaid State Plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

J. Case Records 42 CRF 441.18(a)(7)

Providers maintain case records that document the following for all individuals receiving case management:

a. The name of the individual;
b. The dates of targeted case management services;
c. The name of the provider agency (if relevant) and the person providing the case management service;
d. The nature, content, and units of the targeted case management services received and whether goals specified in the Plan of Care have been achieved;
e. Whether the individual has declined in functioning;
f. The need for and occurrences of coordination with other case managers;
g. A timeline for obtaining needed services; and
h. A timeline for reevaluation of the plan.

K. Limitations

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for services as defined in 440.169 when case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302 F)

Case management does not include, and Federal Financial Participation is not available in expenditures for services as defined in 440.169 when case management activities constitute the direct delivery of underlying medical, education, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program, assessment of adoption placements, recruitment or interviewing of potential foster care parents, serving of legal papers, home investigations, providing transportation, administration of foster care subsidies, or arrangements of placements (42 CFR 441.18(c).

FFP is only available for targeted case management services if there are no other third parties liable to pay for such services, including reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with 1903(c) of the Act 1902(a)(25) and 1905(c).

Writing or entering case notes for the member's case management file and transportation to and from a member or member-related contacts are allowable, but not billable TCM activities.