CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00036/4**

TITLE: **Delaware Diamond State Health Plan**

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

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Delaware's Diamond State Health Plan (DSHP) section 1115(a) Medicaid demonstration extension ("demonstration"). The parties to this agreement are the Delaware Department of Health & Social Services ("state") and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective as of the date of the approval letter, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This demonstration extension is approved through December 31, 2018.

The STCs have been arranged into the following subject areas:

II. PROGRAM DESCRIPTION AND OBJECTIVES

The DSHP section 1115(a) demonstration is designed to use a managed care delivery system to create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance. The initial demonstration was approved in 1995 to mandatorily enroll most Medicaid recipients into managed care organizations (MCOs) beginning January 1, 1996. Using savings achieved under managed care, Delaware expanded Medicaid health coverage to uninsured Delawareans with incomes up to 100 percent of the federal poverty level (FPL) and provides family planning coverage to women losing Medicaid pregnancy coverage at the end of 60 days postpartum or losing DSHP comprehensive benefits and have a family income at or below 200 percent of the FPL. The demonstration was previously renewed on June 29, 2000, December 12, 2003, December 21, 2006, and January 31, 2011.

Through an amendment approved by CMS in 2012, the state was authorized to expand the demonstration to create the Diamond State Health Plan Plus (DSHP-Plus) to mandate care through MCOs for additional state plan populations, including (1) individuals receiving care at nursing facilities (NF) other than intermediate care facilities for the mentally retarded (ICF/MR); (2) children in pediatric nursing facilities; (3) individuals who receive benefits from both Medicaid and Medicare (dual eligibles); and (4) workers with disabilities who Buy-In for coverage. This amendment also added eligibility for the following new demonstration populations: (1) individuals who would previously have been enrolled through the 1915(c) home and community based services (HCBS) waiver program for the Elderly and Disabled (waiver number 0136) – including those receiving services under the Money Follows the Person demonstration; (2) individuals who would previously have been enrolled though the 1915(c) HCBS waiver for Individuals with Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus (HIV/AIDS) Related Diseases (waiver number 4159); (3) individuals residing in NF who no longer meet the current medical necessity criteria for NF services; and (4) adults and children with incomes below 250 percent of the Supplemental Security Income Federal Benefit Rate who are at risk for institutionalization. Additionally, this amendment expanded HCBS to include: (1) cost- effective and medically necessary home modifications; (2) chore services; and (3) home delivered meals.

Through this renewal the demonstration is amended to provide demonstration authority to extend the low income adult demonstration population up to individuals with incomes up to 100 percent of the FPL until December 31, 2013. After that date, this demonstration population will not be necessary because it will be included under the approved state plan as the new adult eligibility group authorized under the Affordable Care Act (ACA). The newly eligible adult group, for individuals with incomes up to 133 percent of the FPL, will receive medical assistance through enrollment in managed care plans pursuant to this demonstration.

The state's goal in implementing the demonstration is to improve the health status of low-income Delawareans by:

- Improving access to health care for the Medicaid population, including increasing options for those who need long-term care (LTC) by expanding access to HCBS;
- Rebalancing Delaware's LTC system in favor of HCBS;
- Promoting early intervention for individuals with, or at-risk, for having, LTC needs;

- Increasing coordination of care and supports;
- Expanding consumer choices;
- Improving the quality of health services, including LTC services, delivered to all Delawareans;
- Creating a payment structure that provides incentives for resources to shift from institutions to community-based LTC services where appropriate;
- Improving coordination and integration of Medicare and Medicaid benefits for full-benefit dual eligibles; and
- Expanding coverage to additional low-income Delawareans.

III. GENERAL PROGRAM REQUIREMENTS

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

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

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy**. The state must, within the time frames specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy statement affecting the Medicaid or CHIP program that occur during this demonstration approval period, unless the provision being changed is expressly identified as not applicable.

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

    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change.

    b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The state will not be required to submit Title XIX or Title XXI State Plan Amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the state

plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

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

    a. An explanation of the public process used by the state, consistent with the requirements of STC 15, to reach a decision regarding the requested amendment;

    b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

    c. An up-to-date CHIP allotment neutrality worksheet, if necessary;

    d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation, including a conforming Title XIX and/or Title XXI state plan amendment, if necessary; and

    e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.**
    a. States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of STC 9.

b. Compliance with Transparency Requirements at 42 CFR §431.412: As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 15, as well as include the following supporting documentation:

i. Demonstration Summary and Objectives. The state must provide a summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

ii. Special Terms and Conditions. The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

iii. Waiver and Expenditure Authorities. The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

iv. Quality. The State must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO), state quality assurance monitoring and quality improvement activities, and any other documentation of the quality of care provided under the demonstration.

v. Compliance with the Budget Neutrality Cap. The state must provide financial data (as set forth in the current STCs) demonstrating that the state has maintained and will maintain budget neutrality for the requested period of extension. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of President's budget and historical trend rates at the time of the extension.

vi. Interim Evaluation Report. The state must provide an evaluation report reflecting the hypotheses being tested and any results available.

vii. Demonstration of Public Notice 42 CFR §431.408. The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR §431.408 including the post-award public input process described in 42 CFR §431.420(c) with a report of the issues raised by the

public during the comment period and how the state considered the comments when developing the demonstration extension application.

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

    a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation SPA. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

    b. The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

    c. Phase-out Plan Requirements. The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

    d. Phase-out Procedures. The state must comply with all notice requirements found in 42 CFR §§431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §§431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

    e. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration whenever it determines

following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.

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

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

14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 Demonstrations at 42 C.F.R. §431.408, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 6, are proposed by the state.

    In states with federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

    In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment, and/or renewal of this demonstration (42 C.F.R. §431.408(b)(3)).The state must also comply with the Public Notice Procedures set forth in 42 CFR §447.205 for changes in statewide methods and standards for setting payment rates.

    The state must also comply with the Public Notice Procedures set forth in 42 CFR §447.205 for changes in statewide methods and standards for setting payment rates.

15. **Post Award Forum:** Within six months of the demonstration's implementation and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medicaid Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of the STC. The state must include a summary in the quarterly report, as specified in STC 67, associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required by STC 68.

16. **FFP.** No federal matching for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

17. **MSIS and T-MSIS (Transformed MSIS) Data Submission.** The state shall submit its MSIS data electronically to CMS in accordance with CMS requirements and timeliness standards, including the required transition to T-MSIS.

IV. ELIGIBILITY

The DSHP demonstration includes four distinct components. The DSHP Medicaid managed care program provides Medicaid state plan benefits through a comprehensive managed care delivery system to most recipients eligible under the state plan. DSHP also includes the Uninsured Adult expansion group which provides Medicaid benefits to adults , and the Family Planning Expansion Program which provides access to family planning and family planning-related services to women with income at or below 200 percent of the FPL who lose Medicaid eligibility 60 days postpartum, Medicaid benefits, or DSHP comprehensive benefits. Additionally, the DSHP demonstration includes the DSHP-Plus program which provides long-term care services and supports (LTSS) to certain individuals under the state plan, and to certain demonstration populations. Further details on these programs are provided in Table A, Sections V through IX of the STCs.

18. **Use of Modified Adjusted Gross Income (MAGI) Based Methodologies For Eligibility Groups Affected By the Demonstration.** Mandatory and optional state plan groups described below derive their eligibility through the Medicaid State Plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State Plan, except as expressly waived in this demonstration and as described in these STCs. Any Medicaid State Plan Amendments to the eligibility standards and methodologies for these eligibility groups, including the conversion to a MAGI standard January 1, 2014, will apply to this demonstration. These state plan eligible beneficiaries are included in the demonstration for use of the managed care network and access to additional benefits not described in the state plan.

Table A. Overview of Eligibility for DSHP and DSHP-Plus

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

State Plan Mandatory Medicaid Eligibility Groups	Description	FPL	Resource Standard	Medicaid Eligibility Group (MEG)	Retroactive Eligibility Procedures	DSHP Benefit Package	DSHP-Plus Benefit Package*	Alternative Benefits Plan Package
Qualified Pregnant Women and Children	§1902(a)(10)(A)(i)(III) §1902(r)(2)	Children: Up to 100% of the FPL Pregnant Women: AFDC limit 59% of the FPL	n/a	<u>If age 20 and under:</u> DSHP TANF Children <u>If age 21 and over:</u> DSHP TANF Adults	n/a	X		
Pregnant women	§1902(a)(10)(A)(i)(IV)	Up to 185% of the FPL	n/a	<u>If age 20 and under:</u> DSHP TANF Children <u>If age 21 and over:</u> DSHP TANF Adults	n/a	X		
Infants less than one year old	§1902(a)(10)(A)(i)(IV)	Up to 185% of the FPL	n/a	DSHP TANF Children	n/a	X		
Children ages 1 through 5 years	§1902(a)(10)(A)(i)(VI)	Up to 133% of the FPL	n/a	DSHP TANF Children	n/a	X		
Children ages 6	§1902(a)(10)(A)(i)(VII)	Up to 100% of the	n/a	DSHP	n/a	X		

State Plan Mandatory Medicaid Eligibility Groups	Description	FPL	Resource Standard	Medicaid Eligibility Group (MEG)	Retroactive Eligibility Procedures	DSHP Benefit Package	DSHP-Plus Benefit Package*	Alternative Benefits Plan Package
through 18 years		FPL		TANF Children				
SSI Adults without Medicare	§1902(a)(10)(A)(i)(I)	Supplemental Security Income (SSI) standard	$2,000 individual $3,000 couple	DSHP SSI Adults	n/a	X	X	
SSI Children without Medicare	§1902(a)(10)(A)(i)(I)	SSI standard	$2,000 individual	DSHP SSI Children	n/a	X	X	
Section 4913 Children – lost SSI because of the PRWORA disability definition	§1902(a)(10)(A)(II)	SSI standard	$2,000 individual	DSHP SSI Children	n/a	X		
Section 1931 Families	§1931 Supplement 12 to Attachment 2.6-A, Page 2	Up to 75% of the FPL (AFDC standard)	n/a	If age 20 and under: DSHP TANF Children If age 21 and over: DSHP TANF Adults	n/a	X		
Child or spousal support extension	§1902(a)(10)(A)(i)(I)	n/a	n/a	If age 20 and under: DSHP TANF Children If age 21 and over: DSHP TANF Adults	n/a	X		
Transitional Medical Assistance	§1925	Up to 185% of the FPL	n/a	DSHP TANF	n/a	X		

State Plan Mandatory Medicaid Eligibility Groups	Description	FPL	Resource Standard	Medicaid Eligibility Group (MEG)	Retroactive Eligibility Procedures	DSHP Benefit Package	DSHP-Plus Benefit Package*	Alternative Benefits Plan Package
				Child or Adult				
Title IV-E foster care and adoption assistance	§1902(a)(10)(A)(I)	n/a	n/a	DSHP TANF Child	n/a	X		
Postpartum medical assistance	§1902(e)(5)	n/a	n/a	DSHP TANF Child or Adult	n/a	X		
Continuous eligibility for pregnancy and postpartum period	§1902(e)(6)	n/a	n/a	DSHP TANF Child or Adult	n/a	X		
Deemed newborns	§1902(e)(4)	n/a	n/a	DSHP TANF Children	n/a	X		
Disabled working individuals receiving SSI	1619(a)	Under our 1634 agreement, SSA determines eligibility for this group. SSI standard for unearned income. Gross earnings must be at or above the substantial gainful activity level for non-blind individuals and blind individuals	$2,000 individual $3,000 couple	DSHP SSI Child or Adult		X		
1619(b)	§1902(a)(10)(A)(i)(II)	SSA determines eligibility for this group. SSI standard for unearned income. Gross earnings must meet the threshold test for section 1619(b)	$2,000 individual $3,000 couple	DSHP SSI Child or Adult	n/a	X		

State Plan Mandatory Medicaid Eligibility Groups	Description	FPL	Resource Standard	Medicaid Eligibility Group (MEG)	Retroactive Eligibility Procedures	DSHP Benefit Package	DSHP-Plus Benefit Package*	Alternative Benefits Plan Package
		eligibility.						
Disabled Adult Children	§1634(c)	SSI standard	$2,000 individual $3,000 couple	DSHP SSI Child or Adult	n/a	X		
Individuals ineligible for SSI/SSP because of requirements prohibited under Medicaid	42 CFR 435.122	SSI standard	$2,000 individual $3,000 couple	DSHP SSI Child or Adult	n/a	X		
Mandatory State supplements	42 CFR 435.130	SSA determines eligibility. SSI standard +mandatory state supplement.	$2,000 individual $3,000 couple	DSHP SSI Child or Adult	n/a	X		
Pickle amendment	P.L. 94-566 Sec. 503 42 CFR 435.135	SSI standard	$2,000 individual $3,000 couple	DSHP SSI Child or Adult	n/a	X		
Disabled widows/widowers	§1634(b) 42 CFR 435.137	SSI standard	$2,000 individual $3,000 couple	DSHP SSI Adults	n/a	X		
Disabled early widows/widowers	§1634(d) 42 CFR 435.138	SSI standard	$2,000 individual $3,000 couple	DSHP SSI Adults	n/a	X		
SSI Adults with Medicare	§1902(a)(10)(A)(i)(I)	SSI standard	$2,000 individual $3,000 couple	DSHP-Plus State Plan	n/a	X	X	
SSI Children with Medicare	§1902(a)(10)(A)(i)(I)	SSI standard	$2,000	DSHP-Plus State Plan	n/a	X	X	
Newly Eligible Group – ages 19 - 64 (Effective January 1, 2014)	§1902(a)(10)(A)(i)(VIII) 42 CFR 435.119	Up to 133% of the FPL	n/a	DSHP State Plan	1st day of the month that application is submitted			X

State Plan Optional Medicaid Eligibility Groups	Description	FPL	Resource Standard	MEG	Retroactive Eligibility Procedures	DSHP Benefit Package	DSHP-Plus Benefit Package
Optional Pregnant women	§1902(a)(10)(A)(ii)(IX) §1902(r)(2)	Above 185 through 200% FPL	n/a	If age 20 and under: DSHP TANF Children If age 21 and over: DSHP TANF Adults	n/a	X	
Optional Infants less than one year old: Optional targeted low-income children	§1902(a)(10)(A)(ii)(IX) §1902(r)(2)	• Children above 185% through 200% may be funded with Title XXI funds if they are uninsured. Insured children are Title XIX. • The State receives Title XXI funds for expenditures for uninsured children meeting the definition specified in section 2110(b)(1) of the Act. Title XIX funds are available if the State exhausts its Title XXI allotment and for insured children. (no Title XIX funds have been used to date)	n/a	DSHP MCHP	n/a	X	
Reasonable Classifications of children under age 21 for whom public agencies are assuming full or partial financial responsibility as outlined	1902(a)(10)(A)(ii)(I) and (IV); 42 CFR 435.222	Up to 75% of the FPL (AFDC income standard)	AFDC resource standard	DSHP TANF Children	n/a	X	

State Plan Optional Medicaid Eligibility Groups	Description	FPL	Resource Standard	MEG	Retroactive Eligibility Procedures	DSHP Benefit Package	DSHP-Plus Benefit Package
in the Medicaid State plan.							
TEFRA Children (Katie Beckett)	§1902(e)(3)	Up to 250% of SSI Standard	$2,000	DSHP SSI Children	n/a	X	
Eligible for cash except for institutional status	§1902(a)(10)(A)(ii)(IV)	SSI standard for ABD AFDC standard for pregnant women and parents/caretaker relatives	For ABD: $2,000 individual $3,000 couple AFDC standard for pregnant women and parents/caretaker relatives	DSHP SSI Child or Adult	n/a	X	
Subsidized adoption children under the age of 21 with special medical needs	§1902(a)(10)(A)(ii)(VIII)	n/a	n/a	DSHP TANF Children	n/a	X	
Optional State supplement – individuals living in an adult residential care facility or assisted living facility	§1902(a)(10)(A)(ii)(IV) 42 CFR 435.232	Individual: SSI standard + $140 Couple: SSI standard +$448	$2,000 individual $3,000 couple	DSHP SSI Children or Adults	n/a	X	X
Optional State supplement – individuals who lose eligibility for Medicaid due to receipt of SSDI and are not yet eligible for Medicare	§1902(a)(10)(A)(ii)(IV) 42 CFR 435.232	$5.00 month	n/a	DSHP SSI Children or Adults	n/a	X	X
Institutionalized individuals in Nursing Facilities who meet the Nursing Facility LOC criteria in place at the	§1902(a)(10)(A)(ii)(V)	Up to 250% of SSI Standard	$2,000 individual $3,000 couple	DSHP-Plus State Plan	3 months prior to application month	X	X

State Plan Optional Medicaid Eligibility Groups	Description	FPL	Resource Standard	MEG	Retroactive Eligibility Procedures	DSHP Benefit Package	DSHP-Plus Benefit Package
time of enrollment into the facility (with and without Medicare) even if they later do not meet the current LOC criteria							
Medicaid for Workers with Disabilities (Medicaid Buy-in)	§1902(a)(10)(A)(ii)(XV)	Up to 275% of the FPL	n/a	DSHP-Plus State Plan	3 months prior to the application month	X	X

Demonstration Eligible Groups	Description	FPL	Resource Standard	MEG	Retroactive Eligibility Procedures	DSHP Benefit Package	DSHP-Plus Benefit Package
Uninsured Adults Expansion Population – age 19 and older (Eligibility group sunsets 12/31/2013)	§1115	Up to 100% of the FPL	n/a	DSHP Exp. Pop.	n/a	X	
Family Planning Only (Eligibility group sunsets 12/31/2013)	§1115	Up to 200% of the FPL	n/a	DSHP Family Planning Expansion	n/a	This population receives only a limited family planning benefit package as outlined in STC 20(c) and Section XI of the STCs	
TEFRA-Like Children (Katie Beckett) using the "at-risk of NF" LOC criteria in place at time of enrollment	§1902(e)(3) Children, ages 18 or younger, who are disabled as described in section 1614(a) of the Social Security Act, who do not meet the NF LOC, but who in the absence of receiving care are "at-risk" of institutionalization and meet an "at-risk of NF" LOC. Use financial institutional eligibility rules for individuals who would not be eligible in the community because of community deeming rules.	Up to 250% of SSI Standard	$2,000	DSHP TEFRA-Like	n/a	X	
Aged and/or disabled categorically needy individuals over age 18 who meet the Nursing Facility LOC criteria in	Use institutional eligibility and post eligibility rules for individuals who would not be eligible in the community because of community	Up to 250% of SSI Standard	$2,000 individual $3,000 couple	DSHP-Plus HCBS	n/a	X	X

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

Demonstration Eligible Groups	Description	FPL	Resource Standard	MEG	Retroactive Eligibility Procedures	DSHP Benefit Package	DSHP-Plus Benefit Package
* Any individual needing Nursing Facility services and is eligible for such services will receive Nursing Facility services through DSHP-Plus.							

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

Table B. Eligibility Exclusions.

Exclusions from DSHP and DSHP-Plus	Description	FPL	Resource Standard	Retroactive Eligibility Procedures
PACE	§1934	Up to 250% of SSI Standard	$2,000 individual $3,000 couple	n/a
Qualified Medicare Beneficiaries (QMB)	§1902(a)(10)(E)(i) §1902(r)(2) used to disregard all resources	Up to 100% of the FPL	$6,680 individual $10,202 couple	n/a
Specified Low Income Medicare Beneficiary (SLMB)	§1902(a)(10)(E)(iii) §1902(r)(2) used to disregard all resources	Up to 120% of the FPL	$6,680 individual $10,202 couple	3 months prior to application month
Qualifying Individuals (QI)	§1902(a)(10)(E)(iv) §1902(r)(2) used to disregard all resources	Up to 135% of the FPL	$6,680 individual $10,202 couple	3 months prior to application month
Qualified and Disabled Working Individuals	§1902(a)(10)(E)(ii) §1902(r)(2) used to disregard all resources	Up to 200% of the FPL	$4,000 individual $6,000 couple	3 months prior to application month
Presumptively eligible pregnant women	§1902(a)(47) §1920	Up to 185% of the FPL	n/a	n/a
Individuals in a hospital for 30 consecutive days*	§1902(a)(10)(A)(ii)(V)	SSI standard	$2,000	3 months prior to the application months
Presumptive Breast and Cervical Cancer for Uninsured Women	§1920B	n/a	n/a	3 months prior to application month
Breast and Cervical Cancer Program for women	§1902(a)(10)(A)(ii)(XVIII)	n/a	n/a	3 months prior to application month
Institutionalized individuals in an ICF/MR	§1902(a)(10)(A)(ii)(V)	250% of SSI Standard	$2,000 individual $3,000 couple	3 months prior to application month

Exclusions from DSHP and DSHP-Plus	Description	FPL	Resource Standard	Retroactive Eligibility Procedures
facility				
Community-based individuals who meet ICF/MR level of care (DDDS/MR 1915c Waiver)	§1902(a)(10)(A)(ii)(VI)	250% of SSI Standard	$2,000 individual $3,000 couple	n/a

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

20. **Eligibility and Post Eligibility Treatment of Income for DSHP-Plus Individuals who are Institutionalized.** The state must follow the rules specified in the currently approved State plan for institutionalized DSHP-Plus participants. All individuals receiving institutional services must be subject to post eligibility treatment of income rules set forth in section 1924 of the Social Security Act and 42 CFR §435.725 of the federal regulations.

21. **Regular and Spousal Impoverishment Post-Eligibility Treatment of Income for DSHP-Plus Individuals Receiving HCBS (Specified at 42 CFR §435.726 of the Federal Regulations and 1924 of the Social Security Act).** For HCBS participants found eligible using institutional eligibility rules and that do not receive services in an Assisted Living Facility, the state will provide a maintenance needs allowance that is equal to the individuals' total income as determined under the post eligibility process, which includes income that is placed in a Miller Trust. For those HCBS participants that elect to receive services in an Assisted Living Facility, the state will provide a maintenance needs allowance set at the Adult Foster Care Rate, which is the SSI standard plus the Optional State Supplement amount.

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

V. DSHP BENEFITS

22. **DSHP Benefits.** Benefits provided through this demonstration for the Medicaid managed care and Family Planning Expansion Programs are described below:

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

    b. **DSHP FFS Benefits.** The following state plan services are carved out from the Medicaid MCO benefit package and are paid on a FFS basis:
        i. Pharmacy;
        ii. Child dental;
        iii. Non-emergency transportation, except for emergency ambulance transportation;

iv. Day habilitation services authorized by the Division of Developmental Disabilities Services;
v. Medically necessary behavioral health services for both children and adults in excess of MCO plan benefit coverage, which is 30 visits for children and 20 visits for adults
vi. Prescribed pediatric extended care.

c. **Family Planning Expansion Program.** The women served under the Family Planning Expansion Program receive a limited benefit package consisting of family planning and family planning-related services as outlined in Section XI of the STCs. This program ends December 31, 2013.

23. **Alternative benefit plan:** The Newly Eligible Group, made eligible under the state plan effective January 1, 2014, will receive benefits described in the state's approved alternative benefit plan (ABP) state plan amendment (SPA), which are effective, as of the effective date in the approved ABP SPA.

24. **Self-Referral.** Demonstration beneficiaries may self-refer for the following services:
- Emergency care;
- Family planning services, including obstetric and gynecology services;
- For female participants, the MCOs must allow direct access to women's health specialists within the health plan's network for covered care related to women's routine and preventive care;
- In-network behavior health services;
- In-network eye health care services for children, including optometry and ophthalmology;
- Evaluation Services from a provider with the Early Childhood Intervention program for children ages 0-3 years with a developmental delay; and
- Generally all specialists (except Neuro-psych).

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

VI. DSHP-PLUS BENEFITS

26. **Eligibility for DSHP-Plus HCBS Benefits.** DSHP-Plus provides HCBS LTSS as identified in Table C to eligible individuals as outlined in Table A. Medical and/or functional needs are assessed according to LOC criteria for NFs, hospitals and "at-risk of NF" criteria published in the state rules. These criteria must be based on accepted medical standards. These LOC criteria must be used in assessing eligibility for DSHP-Plus HCBS benefits at the time of an individual's initial HCBS enrollment. Attachment E outlines the LOC criteria for NFs and hospitals in effect prior to implementation of DSHP-Plus within the demonstration and the LOC criteria for NFs, hospitals, and "at-risk of NF" criteria for initial implementation of DSHP-Plus. The state is required to notify CMS 60 days in advance of

any changes to these LOC criteria and provide an update to this attachment.

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

Table C . DSHP-Plus HCBS

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

28. **Option for Participant Direction of Personal Care Services.** DSHP-Plus participants who elect self-directed care must have the opportunity to have choice and control over how personal care services are provided and who provides the service. Member participation in participant direction is voluntary, and members may participate in or withdraw from participant direction at any time.

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

    b. **Participant Direction by Representative.** The participant who self-directs the personal care service may appoint a volunteer designated representative to assist with or perform employer responsibilities to the extent approved by the participant.

Waiver services may be directed by a legal representative of the participant. Waiver services may be directed by a non-legal representative freely chosen by an adult participant. A person who serves as a representative of a participant for the purpose of directing personal care services cannot serve as a provider of personal attendant services for that participant.

c. **Participant Employer Authority.** The participant (or the participant's representative) must have decision-making authority over workers who provide personal care services.
    i. Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide personal care services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.
    ii. Decision Making Authorities. The participant exercises the following decision making authorities: Recruit staff, select staff from worker registry, hire staff as common law employer, verify staff qualifications, obtain criminal history and/or background investigation of staff, specify additional staff qualifications based on participant needs and preferences, evaluate staff performance, verify time worked by staff and approve time sheets, and discharge staff.

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

e. **Appeals.** The following actions shall be considered an adverse action under both 42 CFR 431 Subpart E (state fair hearing) and 42 CFR §438 Subpart F (MCO grievance process):
    i. A reduction in services; or
    ii. A denial of a requested adjustment to the care plan.

Participants may use either the state fair hearing process or the MCO appeal process to request reconsideration of these adverse actions.

29. **Money Follows the Person (MFP) Demonstration.** Beneficiaries enrolled in the state's MFP program are included in the demonstration. MFP grant funds must pay for MFP services for MFP-eligible participants.

    The MCOs will provide MFP Transition Coordinators and Nurses that will develop transition plans and assist MFP eligible clients in transitioning from institutions to the facility. The MCOs will contract with and reimburse current MFP service vendors. State staff will oversee the MCOs and approve all transition plans developed by the MCOs and approve all discharges.

VII. COST SHARING

30. Co-payments will be charged to all DSHP and DSHP-Plus Managed Care enrollees as stipulated in the state plan. Standard Medicaid exemptions from cost-sharing, such as family planning services, as stipulated in 42 C.F.R. §447(b), apply to the demonstration.

VIII. DSHP AND DSHP-PLUS ENROLLMENT

31. **Mandatory Enrollment.**

    a. **Enrollment.** The state may mandatorily enroll individuals served through this demonstration in managed care programs to receive DSHP and DSHP-Plus benefits pursuant to Sections V, VI and VIII of the STCs. The mandatory enrollment will apply only when the plans in the geographic area have been determined by the state to meet certain readiness and network requirements and require plans to ensure sufficient access, quality of care, and care coordination for beneficiaries established by the state, as required by 42 CFR §438 and approved by CMS. The state must provide updates through its regular meetings with CMS and submit regular documentation requested of its Readiness Review status.

    b. **Choice.** The state must ensure that at the time of initial enrollment and on an ongoing basis, the individuals have a minimum of two plans meeting all readiness requirements from which to choose. If at any time, the state is unable to offer two plans, an alternative delivery system must be available within 60 days of loss of plan choice.

    c. **Notice Requirement for a Change in Network.** The state must provide notice to CMS as soon as it becomes aware of (or at least 90 days prior if possible) a potential change in the number of plans available for choice within an area, or any other changes impacting proposed network adequacy. The State may not mandatorily enroll individuals into any plan that does not meet network adequacy requirements as defined in 42 CFR §438.206.

32. **DSHP Enrollment Process.** All individuals must have the opportunity to make an active selection of a DSHP MCO prior to enrollment. The state will pre-select an MCO for each

DSHP member. That pre-selection shall be based on 42 CFR §438.56, taking into account the MCO affiliation of the individual's historic providers, including those for HCBS services. Once the member is advised of the state's pre-selection, the member will have up to 30 days to choose another MCO. If a different MCO is not selected during that time period, the member will be enrolled into the pre-selected MCO.

33. **DSHP-Plus Enrollment Process.** All individuals must have the opportunity to make an active selection of a DSHP-Plus MCO prior to enrollment. However, similar to DSHP members, the state will pre-select an MCO for each DSHP-Plus member. That pre-selection shall be based on 42 CFR §438.56, taking into account the MCO affiliation of the individual's historic providers, including those for HCBS services. Once the member is advised of the state's pre-selection, the member will have up to 30 days to choose another MCO. If a different MCO is not selected during that time period, the member will be enrolled into the pre-selected MCO.

34. **DSHP and DSHP-Plus Disenrollment.** Individuals must be informed at least annually of their opportunity to change MCOs. Within 90 days of their initial enrollment into an MCO, individuals must be permitted 90 days to change MCOs without cause. After that time period, MCO changes are permitted for cause only.

IX. DELIVERY SYSTEMS

35. **Managed Care Requirements.** The state must comply with the managed care regulations published at 42 CFR §438, except as waived herein. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR §438.6. The certification shall identify historical utilization of state plan and HCBS services used in the rate development process.

36. **Managed Care Benefit Package.** Individuals enrolled in any managed care program within the state must receive from the managed care program the benefits as identified in Sections V and VI of the STCs. As noted in plan readiness and contract requirements, the state must require that each MCO refer and/or coordinate, as appropriate, enrollees' access to needed state plan services that are excluded from the managed care delivery system but available through a fee-for-service delivery system, and must also assure referral and coordination with services not included in the established benefit package.

37. **Managed Care Contracts.** No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR §438 requirements prior to CMS approval of such contracts and/or contract amendments. The State shall submit any supporting documentation deemed necessary by CMS. The state must provide CMS with a minimum of 60 days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.

38. **Public Contracts**. Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred

in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

39. **Network Requirements**. The state must ensure the delivery of all covered benefits, including high quality care. Services must be delivered in a culturally competent manner, and the MCO network must be sufficient to provide access to covered services to the low-income population. In addition, the MCO must coordinate health care services for demonstration populations. The following requirements must be included in the state's MCO contracts:

    a. **Special Health Care Needs.** Enrollees with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 C.F.R. §438.208(c)(4).

    b. **Out of Network Requirements.** Each MCO must provide demonstration populations with all demonstration program benefits described within these STCs and must allow access to non-network providers when services cannot be provided consistent with the timeliness standards required by the state.

40. **Demonstrating Network Adequacy**. Annually, each MCO must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate range of preventive, primary, pharmacy, specialty and HCBS services for the anticipated number of enrollees in the service area.

    a. The state must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:
        i. The number and types of primary care, pharmacy, and specialty providers available to provide covered services to the demonstration population
        ii. The number of network providers accepting the new demonstration population; and
        iii. The geographic location of providers and demonstration populations, as shown through GeoAccess or similar software.

    b. The state must submit the documentation required in subparagraphs i – iii above to CMS with initial MCO contract submission as well as at each contract renewal or renegotiation, or at any time that there is a significant impact to each MCO's operation, including service area expansion or reduction and population expansion.

41. **Revision of the State Quality Strategy.** The state must update its Quality Strategy to reflect all managed care plans operating under the DSHP and DSHP-Plus programs. The state must obtain the input of recipients and other stakeholders in the development of its revised comprehensive Quality Strategy and make the Strategy available for public comment. The state must revise the strategy whenever significant changes are made, including changes through this demonstration. Pursuant to STC 68, the state must also provide CMS with annual reports on the effectiveness of the updated comprehensive Quality Strategy as it impacts the demonstration.

42. **Required Components of the State Quality Strategy.** The revised Quality Strategy shall meet all the requirements of 42 CFR §438 Subpart D. The quality strategy must include components relating to HCBS and must address the following: administrative authority, level of care determinations, service plans, health and welfare, and qualified providers. Additionally, it must also include information on how the state will monitor and evaluate each MCO's compliance with the contract requirements specific to the DSHP-Plus program as outlined in STC 51, including level of care evaluations, service plans, qualified providers as well as how the health and welfare of enrollees will be assessed and monitored.

43. **Required Monitoring Activities by State and/or External Quality Review Organization (EQRO).** The state's EQRO process shall meet all the requirements of 42 CFR §438 Subpart E. In addition, the state, or its EQRO, shall monitor and annually evaluate the MCOs' performance on specific new requirements under DSHP-Plus. These include but are not limited to the following:

    a. Level of care determinations – to ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals being served with LTSS have been assessed to meet the required level of care for those services.

    b. Service plans – to ensure that MCOs are appropriately creating and implementing service plans based on enrollee's identified needs.

    c. MCO credentialing and/or verification policies – to ensure that HCBS services are provided by qualified providers.

    d. Health and welfare of enrollees – to ensure that the MCO, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

44. **Advisory Committee as required in 42 CFR §438**. The state must maintain for the duration of the demonstration a managed care advisory group comprised of individuals and interested parties impacted by the demonstration's use of managed care, regarding the impact and effective implementation of these changes to seniors and persons with disabilities. Membership on this group should be periodically updated to ensure adequate representation of individuals receiving LTSS.

45. **Managed Care Data Requirements.** All managed care organizations shall maintain an information system that collects, analyzes, integrates and reports data as set forth at 42 CFR 438.242. This system shall include encounter data that can be reported in a standardized format. Encounter data requirements shall include the following:

    a. Encounter Data – All managed care organizations in the demonstration shall be responsible for the collection of all data on services furnished to enrollees through encounter data or other methods as specified by the state, and the maintenance of these data at the plan level. The state shall, in addition, develop mechanisms for the

collection, reporting, and analysis of these, as well as a process to validate that each plan's encounter data are timely, complete and accurate. The state will take appropriate actions to identify and correct deficiencies identified in the collection of encounter data. The state shall have contractual provisions in place to impose financial penalties if accurate data are not submitted in a timely fashion.

b. Encounter Data Validation Study for New Capitated Managed Care Plans - If the state contracts with new managed care organizations, the state shall conduct a validation study 18 months after the effective date of the contract to determine completeness and accuracy of encounter data. The initial study shall include validation through a sample of medical records of demonstration enrollees.

c. Submission of Encounter Data - The state shall submit encounter data to the Medicaid Statistical Information System (MSIS) and when required T-MSIS (Transformed MSIS) as is consistent with Federal law. The state must assure that encounter data maintained at managed care organizations can be linked with eligibility files maintained at the state.

46. **External Quality Review (EQR).** The state is required to meet all requirements for external quality review (EQR) found in 42 C.F.R. Part 438, subpart E. The state must amend its current external quality review organization (EQRO) contract to require the validation of encounter data for all MCOs and PIHPs a minimum of once every three years.

The state should generally have available its final EQR technical report to CMS and the public, in a format compliant with Section 508 of the Rehabilitation Act (29 U.S.C. § 794d), by April 30th of each year, for data collected within the prior 15 months. This submission timeframe will align with the collection and annual reporting on managed care data by the Secretary of Health and Human Services each September 30th, which is a requirement under the ACA [Sec. 2701 (d)(2)].

X. HCBS SERVICE DELIVERY AND REPORTING REQUIREMENTS

47. **Home and Community Characteristics.** A home-like character is maintained in non-institutional residential settings. Residential settings provide an environment that is like a home, provides full access to typical facilities in a home such as a kitchen with cooking, facilities, small dining areas, provides for privacy, visitors at times convenient to the individual and supports community integration, including easy access to resources and activities in the community. HCBS LTSS are not provided in institution-like settings except when such settings are employed to furnish short-term respite to individuals.

48. **Administrative Authority.** When there are multiple state entities involved in the administration of the demonstration, The Single State Medicaid Agency must maintain ultimate authority over the program and must exercise appropriate monitoring and oversight over MCOs as well as all entities contracted to assigned administrative functions on behalf of the Medicaid Agency.

49. **Integration of Section 1915(c) Waiver Assurances and Program Requirements into DSHP-Plus**. CMS must expect the state to maintain administrative authority and to implement DSHP-Plus in such a way that the waiver assurances and other program requirements currently part of its 1915(c) waiver programs are met, either by the state or by the MCOs through specific contract provisions, as follows:

    a. Level of Care (LOC) Determinations.
        i. An evaluation for level of care must be given to all applicants for whom there is reasonable indication that services may be needed in the future either by the State, or as a contractual requirement, by the MCO.
        ii. All DSHP-Plus enrollees must be reevaluated at least annually or as otherwise specified either by the state, or as a contractual requirement, by the MCO.
        iii. The LOC process and instruments will be implemented as specified by the state, either through the state's own processes, or as a contractual requirement, by the MCO.

    b. Person-Centered Planning and Individual Service Plans.
        i. The MCO contract shall require the use of a person-centered and directed planning process intended to identify the strengths, capacities, and preferences of the enrollee as well as to identify an enrollee's long term care needs and the resources available to meet these needs, and to provide access to additional care options as specified by the contract. The person-centered plan is developed by the participant with the assistance of the team and those individuals the participant chooses to include. The plan includes the services and supports that the participant needs to live in the community.
        ii. The MCO contract shall require that service plans must address all enrollees' assessed needs (including health and safety risk factors) and personal goals.
        iii. The MCO contract shall require that a process is in place that permits participants to request a change to the person-centered plan if the participant's circumstances necessitate a change. The MCO contract shall require that all service plans are updated and/or revised at least annually or when warranted by changes in the enrollee's needs.
        iv. The MCO contract shall require development of a back-up plan to ensure that needed assistance will be provided in the event that the regular services and supports identified in the individual service plan are temporarily unavailable. The back-up plan may include other individual assistants or services.
        v. The MCO contract shall require that services be delivered in accordance with the service plan, including the type, scope, amount, and frequency.
        vi. The MCO contract shall require that enrollees receiving HCBS services have a choice of provider within the MCO's network.
        vii. The MCO contract shall require policies and procedures for the MCO to monitor appropriate implementation of the individual service plans**.**
        viii. The MCO contract shall utilize the state established minimum guidelines as

outlined in the approved MCO contracts regarding:

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

c. Qualified Providers.

i. The MCO provider credentialing requirement in 42 CFR §438.214 shall apply to all HCBS providers. If the state wishes to change provider qualification standards from those that exist under waivers #0136 and #4159, the state must reach agreement with CMS to do so and ensure that the new standards preserve health and welfare. The state is required to report any changes in provider qualification standards as a part of the quarterly monitoring calls and quarterly reports pursuant to STCs 67 and 68.

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

d. Health and Welfare of Enrollees. The MCO contract shall require the MCO to, on a continuous basis, identify, address, and seek to prevent instances of abuse, neglect and exploitation.

e. Fair Hearings.

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

ii. The MCO contract shall specify whether enrollees must exhaust the MCO's internal appeals process before exercising their right to a state fair hearing.

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

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

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

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

XI. FAMILY PLANNING EXPANSION PROGRAM

This program will expire December 31, 2013.

53. **Eligibility Requirements Effective through December 31, 2013.** Family planning and family planning-related services and supplies are provided to individuals that are redetermined eligible for the program on an annual basis. The state must enroll only women, ages 15 to 50, meeting the eligibility criteria below into the demonstration who have a family income at or below 200 percent of the FPL and who are not otherwise enrolled in Medicaid, Children's Health Insurance Plan (CHIP), or have other health insurance coverage that provides family planning services. Women who are auto enrolled in the Family Planning Expansion group:

    a. Women losing Medicaid pregnancy coverage (SOBRA pregnancy women) at the conclusion of 60 days postpartum and who have a family income at or below 200 percent of the FPL at the time of annual redetermination;

    b. Women losing Medicaid benefits; or

    c. Women losing DSHP comprehensive benefits.

54. **Primary Care Referral.** The state assures CMS that providers of family planning services will make appropriate referrals to primary care providers as medically indicated. The state also assures that individuals enrolled in this demonstration receive information about how to access primary care services.

55. **Eligibility Redeterminations.** The state must ensure that redeterminations of eligibility for this component of the demonstration are conducted, at a minimum, once every 12 months. At the state's option, redeterminations may be administrative in nature.

56. **Disenrollment from the Family Planning Expansion Program.** If a woman becomes pregnant while enrolled in the Family Planning Expansion Program, she may be determined eligible for Medicaid under the state plan. The state must not submit claims under the demonstration for any woman who is found to be eligible under the Medicaid state plan. In addition, women who receive a sterilization procedure and complete all necessary follow-up procedures will be disenrolled from the Family Planning Expansion Program..

57. **Family Planning Expansion Program Benefits.** Benefits for the family planning expansion group are limited to family planning and family planning-related services. Family planning services and supplies described in section 1905(a)(4)(C)and are limited to those services and

supplies whose primary purpose is family planning and which are provided in a family planning setting. Family planning services and supplies are reimbursable at the 90 percent matching rate, including:

a. Approved methods of contraception;

b. Sexually transmitted infection (STI) testing, Pap smears and pelvic exams;
    i. Note: The laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs, blood count and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.

c. Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the state's provider enrollment requirements (subject to the national drug rebate program requirements); and

d. Contraceptive management, patient education, and counseling.

58. **Family Planning-Related Expansion Program Benefits.** Family planning-related services and supplies are defined as those services provided as part of or as follow-up to a family planning visit and are reimbursable at the state's regular Federal Medical Assistance Percentage (FMAP) rate. Such services are provided because a "family planning-related" problem was identified/or diagnosed during a routine or periodic family planning visit. The following are examples of family-planning related services and supplies:

    a. Colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit.

    b. Drugs for the treatment of STIs, except for HIV/AIDS and hepatitis, when the STI is identified/ diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may be covered. In addition, subsequent follow-up visits to rescreen for STIs based on the Centers for Disease Control and Prevention guidelines may be covered.

    c. Drugs /treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, when the conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/ drugs may also be covered.

    d. Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.

e. Treatment of major complications arising from a family planning procedure such as:
    i. Treatment of a perforated uterus due to an intrauterine device insertion;
    ii. Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or
    iii. Treatment of surgical or anesthesia-related complications during a sterilization procedure.

59. **Primary Care Referrals.** Primary care referrals to other social service and health care providers as medically indicated are provided; however, the costs of those primary care services are not covered for enrollees of this demonstration. The state must facilitate access to primary care services for participants, and must assure CMS that written materials concerning access to primary care services are distributed to demonstration participants. The written materials must explain to the participants how they can access primary care services.

60. **Delivery System for Family Planning Expansion Program.** Services provided through this Family Planning Expansion Program are paid FFS.

XII. GENERAL REPORTING REQUIREMENTS

61. **General Financial Requirements.** The state must comply with all general financial requirements under title XIX set forth in Section XIII of these STCs.

62. **Compliance with Managed Care Reporting Requirements.** The state must comply with all managed care reporting regulations at 42 CFR §438 et. seq. except as expressly identified as not applicable in the expenditure authorities incorporated into these STCs.

63. **Reporting Requirements Related to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality set forth in Section XII of these STCs.

64. **Quarterly Monitoring Calls.** The state must participate in monitoring calls with CMS. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments, rate certifications, changes in provider qualification standards, on-going monitoring and oversight), health care delivery, enrollment, cost sharing, any proposed change to LOC criteria, quality of care, access, family planning issues, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, proposed changes in payment rates, MCO financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, any demonstration amendments, concept papers, or state plan amendments the state is considering submitting. The state and CMS shall discuss quarterly expenditure reports submitted by the state for purposes of monitoring budget neutrality. CMS shall update the state on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

65. **Quarterly Reports.** The state must submit progress reports in the format specified in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:

    a. An updated budget neutrality monitoring spreadsheet;

    b. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: systems and reporting issues, approval and contracting with new plans; benefits; enrollment; grievances; proposed or implemented LOC changes; quality of care; changes in provider qualification standards; access; proposed changes to payment rates; health plan financial performance and the implementation of MLTSS, that is relevant to the demonstration; pertinent legislative activity; and other operational issues;

    c. Action plans for addressing any policy and administrative issues identified;

    d. Network adequacy reporting from plans including GeoAccess mapping, customer service reporting including average speed of answer at the plans and call abandonment rates; summary of MCO appeals for the quarter including overturn rate and any trends identified; enrollee complaints and grievance reports to determine any trends; and summary analysis of MCO critical incident report which includes, but is not limited to, incidents of abuse, neglect and exploitation;

    e. Quarterly enrollment reports that include the member months for each demonstration population;

    f. Notification of any changes in enrollment and/or participation that fluctuate 10 percent or more in relation to the previous quarter within the same DY and the same quarter in the previous DY; and

    g. Evaluation activities and interim findings.

66. **Annual Report.** The annual report must, at a minimum, include the requirements outlined below. The state must submit the draft annual report no later than April 1 after the close of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

    a. All items included in the quarterly report pursuant to STC 67(a)-(d) and (f)-(h) must be summarized to reflect the operation/activities throughout the DY;

    b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;

    c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as

required to evaluate compliance with the budget neutral agreement;

d. Quality Strategy. Pursuant to STC 42, the state must report on the effectiveness of the updated comprehensive Quality Strategy as it impacts the demonstration;

e. Managed Care Delivery System. The state must document accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, progress on implementing cost containment initiatives and policy and administrative difficulties in the operation of the demonstration. The state must provide the CAHPS survey, outcomes of any focused studies conducted and what the state intends to do with the results of the focused study, outcomes of any reviews or interviews related to measurement of any disparities by racial or ethnic groups, annual summary of network adequacy by plan including an assessment of the provider network pre and post implementation and MCO compliance with provider 24/7 availability, summary of outcomes of any on-site reviews including EQRO, financial, or other types of reviews conducted by the state or a contractor of the state, summary of performance improvement projects being conducted by the state and any outcomes associated with the interventions, outcomes of performance measure monitoring, summary of plan financial performance; and

f. Family Planning Expansion Program. Additionally, for the Family Planning Expansion Program, the state must provide the following:
   i. The average total Medicaid expenditures for a Medicaid-funded birth each DY. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth up to age 1 (the services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants);
   ii. The number of actual births that occur to family planning demonstration participants within the DY. (participants include all individuals who obtain one or more covered medical family planning services through the family planning program each year);
   iii. Total number of participants for the DY (participants include all individuals who obtain one or more covered family planning services through the demonstration).

67. **Final Report.** Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments.

XIII. GENERAL FINANCIAL REQUIREMENTS

68. **Quarterly Reports.** The state must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration

period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XIV of the STCs.

69. **Reporting Expenditures Under the Demonstration.** The following describes the reporting of expenditures subject to the budget neutrality agreement:

    a. Tracking Expenditures. In order to track expenditures under this demonstration, Delaware will report demonstration expenditures through the Medicaid and state Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 and Section 2115 of the state Medicaid Manual. All demonstration expenditures subject to the budget neutrality limit must be reported each quarter on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on the appropriate prior period adjustment schedules (Forms CMS-64.9 Waiver) for the Summary Line 10B, in lieu of Lines 9 or l0C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality limit," is defined below in Section XV.

    b. Tracking Family Planning Expenditures. For the family planning expansion component of the demonstration, the state should report demonstration expenditures on Forms CMS-64.9 Waiver and/or 64.9P Waiver as follows:
        i. Allowable family planning-related expenditures eligible for reimbursement at the state's federal medical assistance percentage rate (FMAP) should be entered in Column (B) on the appropriate waiver sheets.
        ii. Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate should be entered in Column (D) on the appropriate waiver sheets

    c. Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

    d. Premium and Cost Sharing Contributions. Premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by DY on the Form CMS-64 Narrative. In the calculation of expenditures subject to the

budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

e. Pharmacy Rebates. Pharmacy rebates must be reported on Form CMS-64.9 Base, and not allocated to any Form 64.9 or 64.9P Waiver.

f. Mandated Increase in Physician Payment Rates in 2013 and 2014. Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to pay physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014. The federal government provides a Federal medical assistance percentage of 100 percent for the claimed amount by which the minimum payment exceeds the rates paid for those services as of July 1, 2009. The state will exclude from the budget neutrality test for this demonstration the portion of the mandated increase for which the federal government pays 100 percent.

g. Use of Waiver Forms. For each demonstration year, eleven (11) separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver name noted below, to report expenditures for the following demonstration populations, . Table A outlines the Medicaid eligibility group for each DSHP and DSHP-Plus eligibility group. The waiver names to be used to identify these separate Forms CMS-64.9 Waiver and/or 64.9P Waiver appear in brackets. Expenditures should be allocated to these forms based on the guidance found below.

i. **Demonstration Population 1:** TANF Children less than 21 [DSHP TANF Children]

ii. **Demonstration Population 2:** TANF Adults aged 21and over [DSHP TANF Adult]

iii. **Demonstration Population 3:** Disabled Children less than 21 [DSHP SSI Children]

iv. **Demonstration Population 4:** Aged and Disabled Adults 21and older [DSHP SSI Adults]

v. **Demonstration Population 5:** Infants less than one year of age with income levels above 185 percent FPL through 200 percent FPL. See section (g) below for specific reporting guidelines. [DSHP MCHP]

vi. **Demonstration Population 6:** Uninsured Adults Expansion Population up to 100

percent FPL
[DSHP Exp. Pop.]

vii. **Demonstration Population 7:** Family Planning Expansion
[FP Expansion]

viii. **Demonstration Population 8:** DSHP-Plus State Plan

ix. **Demonstration Population 9:** DSHP-Plus HCBS

x. **Demonstration Population 10:** DSHP TEFRA-Like

xi. **Demonstration Population 11:** Newly Eligible Group up to 133 percent FPL

h. Specific Reporting Requirements for Demonstration Population 5.

i. As outlined in Table A, uninsured children above 185 percent through 200 percent of the FPL are funded with Title XXI funds. Insured children above 185 percent through 200 percent of the FPL are funded with Title XIX funds. The state is eligible to receive title XXI funds for expenditures for these uninsured children meeting the definition specified in section 2110(b)(1) of the Social Security Act, up to the amount of its title XXI allotment. Expenditures for these children under title XXI must be reported on separate Forms CMS-64.21U and/or 64.21UP in accordance with the instructions in section 2115 of the State Medicaid Manual.

ii. Title XIX funds for these uninsured children meeting the definition specified in section 2110(b)(1) of the Social Security Act are available under this demonstration if the state exhausts its title XXI allotment once timely notification as described in subparagraph (iii) has been provided.

iii. If the state exhausts its title XXI allotment prior to the end of a federal fiscal year, title XIX federal matching funds are available for these children. During the period when title XIX funds are used, expenditures related to this demonstration population must be reported as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver. To initiate this:

1) The state shall provide CMS with 120 days prior notice before it begins to draw down title XIX matching funds for this demonstration population;

2) The state shall submit:
   a) An updated budget neutrality assessment that includes a data analysis which identifies the specific "with waiver" impact of the proposed change on the current budget neutrality

expenditure cap. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as result of the proposed change which isolates (by Eligibility Group) the impact of the change;

b) An updated CHIP allotment neutrality worksheet.

iv. The expenditures attributable to this demonstration population will count toward the budget neutrality expenditure cap calculated under STC 72, using the per member per month (PMPM) amounts for TANF Children described in STC 85(a)(ii), and will be considered expenditures subject to the budget neutrality cap as defined in STC 72, so that the state is not at risk for claiming title XIX Federal matching funds when title XXI funds are exhausted.

70. **Expenditures Subject to the Budget Neutrality Cap.** For purposes of this section, the term "expenditures subject to the budget neutrality cap" must include all Medicaid expenditures related to the demonstration benefit package described in sections V and VI of the STCs provided to individuals who are enrolled in this demonstration as described in STC 71(f)(i-x), subject to the limitation specified in STC 71(g). All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

71. **Title XIX Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

72. **Claiming Period.** All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

73. **Reporting Member Months.** The following describes the reporting of member months for demonstration populations:

a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 67, the actual number of eligible member months for the demonstration populations defined in STC 71(f)(i-x). The state must submit a statement accompanying the quarterly

report, which certifies the accuracy of this information.

b. To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

c. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member months.

74. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. Delaware must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

75. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in Section XIV of the STCs:

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

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

    c. Net medical assistance expenditures made under section 1115 demonstration authority under the DSHP.

76. **Extent of Federal Financial Participation for Family Planning Expansion Program.** CMS shall provide FFP for family planning and family planning-related services and supplies at the applicable federal matching rates described in STCs 60 and 61, subject to the limits and processes described below:

    a. For family planning services, reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service.

b. Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate, as described in STC 60, should be entered in Column (D) on the Forms CMS-64.9 Waiver.

c. Allowable family planning-related expenditures eligible for reimbursement at the FMAP , as described in STC 61, should be entered in Column (B) on the Forms CMS-64.9 Waiver.

d. FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the 90 percent federal matching rate. The match rate for the subsequent treatment would be paid at the applicable federal matching rate for the state. For testing or treatment not associated with a family planning visit, no FFP will be available.

e. Pursuant to 42 CFR §433.15(b)(2), FFP is available at the 90 percent administrative match rate for administrative activities associated with administering the family planning services provided under the demonstration including the offering, arranging, and furnishing of family planning services. These costs must be allocated in accordance with OMB Circular A-87 cost allocation requirements. The processing of claims is reimbursable at the 50 percent administrative match rate.

The Family Planning Expansion Program expires December 31, 2013. There will no longer be FFP for services provided if they are billed under this program after December 31, 2013.

77. **Sources of Non-Federal Share.** The state must certify that matching the non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. CMS shall review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

78. **State Certification of Funding Conditions.** The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

    a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.

    b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

    c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

    d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.

    e. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

79. **Monitoring the Demonstration.** The state will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.

80. **Program Integrity.** The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

XIV. MONITORING BUDGET NEUTRALITY

81. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

82. **Risk.** Delaware shall be at risk for the per capita cost (as determined by the method described below) for demonstration eligibles under this budget neutrality agreement, but not for the number of demonstration eligibles. Because CMS provides FFP for all demonstration eligibles, Delaware shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Delaware at risk for the per capita costs for current eligibles, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures had there been no demonstration.

83. **Demonstration Populations Used to Calculate the Budget Neutrality Expenditure Cap.** For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described in the chart below. The federal share of this limit will be calculated by multiplying the total computable budget neutrality limit by Composite Federal Share, which is defined in section (a) below. The demonstration expenditures subject to the budget neutrality limit are those reported under the following Waiver Names (TANF, SSI, DSHP-Plus State Plan, and DSHP TEFRA-Like) plus any excess spending from the Supplemental Tests described in STC 84.

Eligibility Group	**Growth Rate**	**DY 19 CY 2014 PMPM**	**DY 20 CY 2015 PMPM**	**DY 21 CY 2016 PMPM**	**DY22 CY 2017 PMPM**	**DY23 CY 2018 PMPM**
Mandatory and Optional State Plan Groups						
DSHP TANF Children	5.00%	$413.82	$434.51	$456.24	$479.05	$503.00
DSHP TANF Adult	5.16%	$685.11	$720.46	$757.64	$796.73	$837.84
DSHP SSI Children	5.00%	$2,360.45	$2,478.47	$2,602.39	$2,732.51	$2,869.14
DSHP SSI Adults	4.5%	$2,404.12	$2,512.31	$2,625.36	$2,743.50	$2,866.96
DSHP-Plus State Plan	2.76%	$2,528.14	$2,597.92	$2,669.62	$2,743.30	$2,819.02

Eligibility Group	Growth Rate	DY 19 CY 2014 PMPM	DY 20 CY 2015 PMPM	DY 21 CY 2016 PMPM	DY22 CY 2017 PMPM	DY23 CY 2018 PMPM
Hypothetical Populations*						
Newly Eligible Group	5.1%	$929.04	$976.42	$1,026.23	$1,078.57	$1,1335.58
DSHP TEFRA-Like	5.00%	$2,360.45	$2,478.47	$2,602.39	$2,732.51	$2,869.14

* The Newly Eligible Group and DSHP TEFRA-Like are "pass-through" or "hypothetical" populations. Therefore, the state may not derive savings from these populations.

a. Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the extension approval period, as reported on the forms listed in STC 71(f) above, by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period (see STC 11), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of the Composite Federal Share may be used.

b. The overall budget neutrality expenditure cap for the demonstration is the sum of the annual budget neutrality expenditure caps calculated in subparagraph (a)(iii). The federal share of the overall budget neutrality expenditure cap (calculated as the product of the overall budget neutrality cap times the Composite Federal Share) represents the maximum amount of FFP that the state may receive for expenditures on behalf of demonstration populations described in STC 71(f) during the demonstration period reported in accordance with STC 71.

84. **Supplemental Budget Neutrality Test: Newly Eligible Group.** Adults eligible for Medicaid as the group defined in section 1902(a)(10)(A)(i)(VIII) of the ACA are included in this demonstration, and in the budget neutrality. The state will not be allowed to obtain budget neutrality "savings" from this population. Therefore, a separate expenditure cap is established for this group, to be known as the Supplemental Budget Neutrality Test.

a. The MEG listed in the table below is included in Supplemental Budget Neutrality Test.

MEG	TREND	DY 19 CY 2014 PMPM	DY 20 CY 2015 PMPM	DY 21 CY 2016 PMPM	DY22 CY 2017 PMPM	DY23 CY 2018 PMPM
Newly Eligible Group	5.1%	$463.14	$486.76	$511.58	$537.68	$565.10

b. If the state's experience of the take up rate for the Newly Eligible Group and other factors that affect the costs of this population indicates that the PMPM limit described above in paragraph (a) may underestimate the actual costs of medical assistance for the Newly

Eligible Group, the state may submit an adjustment to paragraph (a) for CMS review without submitting an amendment pursuant to STC 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.

c. The Supplemental Cap is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across groups and DYs. The federal share of the Supplemental Cap is obtained by multiplying total computable Supplemental Cap by the Composite Federal Share.

d. Supplemental Budget Neutrality Test is a comparison between the federal share of the Supplemental Cap and total FFP reported by the state for Newly Eligible Group.

e. If total FFP for Newly Eligible Group should exceed the federal share of Supplemental Cap after any adjustments made to the budget neutrality limit as described in paragraph b, the difference must be reported as a cost against the budget neutrality limit.

85. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

86. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

Year	Cumulative target definition	Percentage
DY 19	Cumulative budget neutrality limit plus:	2.0 percent
DY 19 & 20	Cumulative budget neutrality limit plus:	1.5 percent
DY 19 through 21	Cumulative budget neutrality limit plus:	1.0 percent
DY 19 through 22	Cumulative budget neutrality limit plus:	0.5 percent
DY 19 through 23	Cumulative budget neutrality limit plus:	0 percent

87. **Expenditure Containment Initiatives.** In order to ensure that the demonstration remains budget neutral during the extension period, the state shall consider implementing new

initiatives and/or strategies. Possible areas of consideration may include, but are not limited to, pharmacy utilization, MCO rates, benchmarking the services covered, expansion of co-pays and new initiatives related to behavioral health. The state will inform CMS of the cost-containment initiatives that it considers implementing and its progress through the quarterly and annual reports required under STCs 67 and 68, respectively.

88. **Exceeding Budget Neutrality.** If, at the end of this demonstration period, the cumulative budget neutrality expenditure cap has been exceeded, the excess federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

XV. EVALUATION OF THE DEMONSTRATION

89. **Submission of Draft Evaluation Design.** The state shall submit to CMS for approval within 120 days from the award of the demonstration extension a draft evaluation design. Within 120 days of the award of the demonstration amendment, the state much submit a revised draft evaluation design pursuant to subparagraph (a). At a minimum, the draft design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target populations for the demonstration. The draft design must discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The draft design must identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

    a. Domain of Focus: The Evaluation Design must, at a minimum, address the research questions/topics listed below and the goals of the demonstration as outlined in Section I of the STCs. For questions that cover broad subject areas, the state may propose a more narrow focus of the evaluation.
        i. The impact of rebalancing the LTC system in favor of HCBS;
        ii. The costs and benefits of providing early intervention for individuals with, or at-risk, for having LTC needs; and
        iii. The cost-effectiveness and efficiency of DSHP-Plus in ensuring that appropriate health care services are provided in an effective and coordinated fashion.

90. **Interim Evaluation Reports.** In the event the state requests to extend the demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of its request for each subsequent renewal.

91. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft evaluation design described in STC 91 within 60 days of receipt, and the state shall submit a

final design within 60 days of receipt of CMS comments. The state must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The state must submit to CMS a draft of the evaluation report within 120 days after expiration of the demonstration. CMS must provide comments within 60 days after receipt of the report. The state must submit the final evaluation report within 60 days after receipt of CMS comments.

92. **Cooperation with CMS Evaluators.** Should CMS conduct an independent evaluation of any component of the demonstration, the state will cooperate fully with CMS or the independent evaluator selected by CMS. The state will submit the required data to the contractor or CMS.

XVI. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

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

Date - Specific	Deliverable	STC Reference
90 days from January 1, 2014	Submit State Quality Strategy	Section IX, STC 39
120 days from January 1, 2014	Submit Draft Evaluation Plan, including Evaluation Designs for DSHP and DSHP-Plus	Section XV, STC 91
60 days of receipt of CMS comments	Submit Final Evaluation Report	Section XV, STC 93
60 days prior to implementation of any LOC changes	LOC Criteria, required to share a revised Attachment E	Section VI, STC 7

	Deliverable	STC Reference
Annual	By April 1st - Draft Annual Report	Section XII, STC 68
Each Quarter (02/28, 05/31, 08/31, 11/30)		
	Quarterly Operational Reports	Section XII, STC 67
	Quarterly Enrollment Reports	Section XII, STC 67
	CMS-64 Reports	Section XIII, STC 70
	Eligible Member Months	Section XIII STC 74

ATTACHMENT A

Quarterly Report Content and Format

Under Section XII, STC 67, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

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

NARRATIVE REPORT FORMAT:

Title Line One – Diamond State Health Plan

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

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

Introduction

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

Enrollment Information

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

Enrollment Counts

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

Demonstration Populations (as hard coded in the CMS 64)	**Current Enrollees** (to date)	**Disenrolled in Current Quarter**
Population 1: Former AFDC Children less than 21 [DSHP TANF Children]		
Population 2: Former AFDC Adults aged 21and over [DSHP TANF Adult]		
Population 3: Disabled Children less than 21 [DSHP SSI Children]		
Population 4: Aged and Disabled Adults 21 and older [DSHP SSI Adults]		
Population 5: Infants less than one year of age with income levels above 185 percent FPL through 200 percent FPL: optional targeted low income children. [DSHP MCHP]		
Population 6: Uninsured Adults up to 100% FPL [DSHP Exp. Pop.]		

ATTACHMENT A

Quarterly Report Content and Format

Demonstration Populations (as hard coded in the CMS 64)	**Current Enrollees** (to date)	**Disenrolled in Current Quarter**
Population 7: Family Planning Expansion [FP Expansion]		
Population 8: DSHP-Plus State Plan		
Population 9: DSHP-Plus HCBS		
Population 10: DSHP TEFRA-Like		
Population 11: Newly Eligible Group		

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

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

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

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

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

A. For Use in Budget Neutrality Calculations

Eligibility Group	**Month 1**	**Month 2**	**Month 3**	**Total for Quarter Ending XX/XX**
DSHP TANF Children				
DSHP TANF Adult				
DSHP SSI Children				
DSHP SSI Adults				
DSHP MCHP (Title XIX match)*				
DSHP Exp. Pop.				

FP Expansion				
DSHP-Plus State Plan				
DSHP-Plus HCBS				
DSHP TEFRA-Like				
Newly Eligible Group				
* This EG does not include children funded through title XXI. Please note within the report, if the state must use title XIX funds for other uninsured children meeting the definition specified in section 2110(b)(1) of the Social Security Act if the state exhausts title XXI funds.				

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

B. For Informational Purposes Only

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

Consumer Issues

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

Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity in current quarter. As part of the annual report, pursuant to STCs 40 and 41, the state must also report on the effectiveness of the updated comprehensive Quality Strategy as it impacts the demonstration.

ATTACHMENT A

Quarterly Report Content and Format

Managed Care Reporting Requirements

Address network adequacy reporting from plans including GeoAccess mapping, customer service reporting including average speed of answer at the plans and call abandonment rates; summary of MCO appeals for the quarter including overturn rate and any trends identified; enrollee complaints and grievance reports to determine any trends; and summary analysis of MCO critical incident report which includes, but is not limited to, incidents of abuse, neglect and exploitation. The state must include additional reporting requirements within the annual report as outlined in STC 63(e).

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments

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

State Contact(s)

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

ATTACHMENT B

Historical Budget Neutrality Data

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

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

			TANF Children		**TANF Adults**		**SSI Children**		**SSI Adults**	
DY	Time Period	Service Category	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM
1	FFY 1996	*Pharmacy*	25.3%	$ 9.66	32%	$ 29.08	21%	$ 51.51	27.4%	$ 58.95
		Behavioral Health	29.8%	$ 31.64	29.8%	$ 1.15	29.8%	$ 85.17	29.8%	$ 119.28
		Managed Care	6.79%	$ 92.60	6.17%	$ 215.39	6.85%	$ 647.08	6.85%	$ 523.85
2	FFY 1997	*Pharmacy*	6.79%	$ 10.31	6.17%	$ 30.87	6.85%	$ 55.04	6.85%	$ 169.84
		Behavioral Health	6.79%	$ 33.79	6.17%	$ 1.22	6.85%	$ 85.17	6.85%	$ 119.28
		Managed Care	6.79%	$ 98.89	6.17%	$ 228.67	6.85%	$ 691.41	6.85%	$ 559.74
3	FFY 1998	*Pharmacy*	6.79%	$ 11.01	6.17%	$ 32.78	6.85%	$ 58.81	6.85%	$ 181.47
		Behavioral Health	6.79%	$ 36.08	6.17%	$ 1.29	6.85%	$ 97.23	6.85%	$ 136.19
		Managed Care	6.79%	$ 105.60	6.17%	$ 242.78	6.85%	$ 738.77	6.85%	$ 598.08
4	FFY 1999	*Pharmacy*	6.79%	$ 11.76	6.17%	$ 34.80	6.85%	$ 62.83	6.85%	$ 193.90
		Behavioral Health	6.79%	$ 38.53	6.17%	$ 1.37	6.85%	$ 103.89	6.85%	$ 145.51
		Managed Care	6.79%	$ 112.77	6.17%	$ 257.76	6.85%	$ 789.37	6.85%	$ 639.05
5	FFY 2000	*Pharmacy*	6.79%	$ 12.56	6.17%	$ 36.95	6.85%	$ 67.14	6.85%	$ 207.18
		Behavioral Health	6.79%	$ 41.15	6.17%	$ 1.46	6.85%	$ 111.01	6.85%	$ 155.48
		Managed Care	6.79%	$ 120.43	6.17%	$ 273.67	6.85%	$ 843.45	6.85%	$ 682.82
6	FFY 2001	*Pharmacy*	6.79%	$ 13.41	6.17%	$ 39.23	6.85%	$ 71.74	6.85%	$ 221.37
		Behavioral Health	6.79%	$ 43.94	6.17%	$ 1.55	6.85%	$ 118.62	6.85%	$ 166.13
		Managed Care	6.79%	$ 128.61	6.17%	$ 290.55	6.85%	$ 901.22	6.85%	$ 729.59
7	FFY 2002	*Pharmacy*	6.79%	$ 14.32	6.17%	$ 41.65	6.85%	$ 76.65	6.85%	$ 236.54
		Behavioral Health	6.79%	$ 46.93	6.17%	$ 1.64	6.85%	$ 126.74	6.85%	$ 177.51

ATTACHMENT B

Historical Budget Neutrality Data

		Managed Care	6.79%	$ 137.34	6.17%	$ 308.48	6.85%	$ 962.95	6.85%	$ 779.57
8	FFY 2003	*Pharmacy*	6.79%	$ 15.29	6.17%	$ 44.22	6.85%	$ 81.90	6.85%	$ 236.54
		Behavioral Health	6.79%	$ 50.11	6.17%	$ 1.74	6.85%	$ 135.42	6.85%	$ 189.67
		Managed Care	6.79%	$ 146.67	6.17%	$ 327.51	6.85%	$ 1,028.92	6.85%	$ 832.97
	Oct – Dec. 2003	*Pharmacy*	6.79%	$ 15.54	6.17%	$ 44.89	6.85%	$ 83.27	6.85%	$ 256.96
		Behavioral Health	6.79%	$ 50.94	6.17%	$ 1.77	6.85%	$ 137.68	6.85%	$ 192.84
		Managed Care	6.79%	$ 149.10	6.17%	$ 332.45	6.85%	$ 1,046.10	6.85%	$ 846.88

ATTACHMENT B

Historical Budget Neutrality Data

			TANF Children		TANF Adults		SSI Children		SSI Adults	
DY	Time Period	Service Category	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM
9	CY 2004	*Pharmacy*	6.79%	$ 16.60	6.17%	$ 47.66	6.85%	$ 88.97	6.85%	$ 74.56
		Behavioral Health	6.79%	$ 54.40	6.17%	$ 1.88	6.85%	$ 147.11	6.85%	$ 206.05
		Managed Care	6.79%	$ 159.22	6.17%	$ 352.96	6.85%	$ 1,117.76	6.85%	$ 904.89
10	CY 2005	*Pharmacy*	6.79%	$ 17.73	6.17%	$ 50.60	6.85%	$ 95.07	6.85%	$ 93.37
		Behavioral Health	6.79%	$ 58.09	6.17%	$ 1.99	6.85%	$ 157.19	6.85%	$ 220.16
		Managed Care	6.79%	$ 170.03	6.17%	$ 374.74	6.85%	$ 1,194.33	6.85%	$ 966.88
11	CY 2006	*Pharmacy*	6.79%	$ 18.93	6.17%	$ 53.72	6.85%	$ 101.58	6.85%	$ 13.47
		Behavioral Health	6.79%	$ 62.04	6.17%	$ 2.11	6.85%	$ 167.96	6.85%	$ 235.25
		Managed Care	6.79%	$ 181.58	6.17%	$ 397.86	6.85%	$ 1,276.14	6.85%	$ 1,033.11
12	CY 2007	[redacted]	5.84%	$ 280.38	5.16%	$ 481.68	5.42%	$ 1,651.56	5.84%	$ 1,690.19
13	CY 2008		5.84%	$ 296.75	5.16%	$ 506.54	5.42%	$ 1,741.07	5.84%	$ 1,781.79
14	CY 2009		5.84%	$ 314.08	5.16%	$ 532.54	5.42%	$ 1,835.44	5.84%	$ 1,878.37
15	CY 2010		5.84%	$332.40	5.16%	$560.21	5.20%	$1,930.89	5.20%	$1,976.02
16	CY 2011		5.84%	$351.81	5.16%	$589.12	5.20%	$2,031.30	5.20%	$2,078.77
17	CY 2012		5.84%	$372.36	5.16%	$619.52	5.20%	$2,136.93	5.20%	$2,186.87
18	CY 2013		5.84%	$394.11	5.16%	$651.49	5.20%	$2,248.05	5.20%	$2,300.59

ATTACHMENT C

DSHP-Plus HCBS Service Definitions

HCBS Service	Service Definition
Case Management	Case management includes services assisting participants in gaining access to needed demonstration and other state plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case managers are responsible for the ongoing monitoring of the provision of services included in the participant's service plan and/or participant health and welfare. Case managers are responsible for initiating the process to evaluate the/or re-evaluate the individual's level of care and/or the development of service plans. Case managers are responsible for assisting the participant in gaining access to needed services regardless of the funding source. All DSHP-Plus members will receive case management. The case manager provides intensive case management for DSHP-Plus members in need of long term care services though service planning and coordination to identify services; brokering of services to obtain and integrate services, facilitation and advocacy to resolve issues that impede access to needed services; monitoring and reassessment of services based on changes in member's condition; and gate keeping to assess and determine the need for services to members.
Community-based residential alternatives that include Assisted Living Facilities	Community-based residential services offer a cost-effective, community based alternative to nursing facility care for persons who are elderly and/or adults with physical disabilities. This currently includes assisted care living facilities. Community-based residential services include personal care and supportive services (homemaker, chore, attendant services, and meal preparation) that are furnished to participants who reside in homelike, non-institutional settings. Assisted living includes a 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming, and medication assistance (to the extent permitted under state law). As needed, this service may also include prompting to carry out desired behaviors and/or to curtail inappropriate behaviors. Services that are provided by third parties must be coordinated with the assisted living provider. Personal care services are provided in assisted living facilities as part of the community-based residential service. To avoid duplication, personal care (as a separate service) is not available to persons residing in assisted living facilities.

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DSHP-Plus HCBS Service Definitions

HCBS Service	Service Definition
Personal Care/ Attendant Care Services	Personal care includes assistance with ADLs (e.g. bathing, dressing, personal hygiene, transferring, toileting, skin care, eating and assisting with mobility). When specified in the service plan, this service includes assistance with instrumental activities of daily living (IADLs) (e.g. light housekeeping chores, shopping, meal preparation). Assistance with IADLs must be essential to the health and welfare of the participant based on the assessment of the Case Manager and with input from the participant and their family caregivers. This service is not available to persons residing in Assisted Living.
Respite Care	Respite care includes services provided to participants unable to care for themselves furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. FFP is not claimed for the cost of room and board. This is provided both at home and in Nursing and Assisted Living Facilities. This service is limited to no more than fourteen (14) days per year. The managed care organization may authorize service request exceptions above these limits on a case-by-case basis when it determines that: • No other service options are available to the member, including services provided through an informal support network; • The absence of the service would present a significant health and welfare risk to the member; and • Respite service provided in a nursing home or assisted living facility is not utilized to replace or relocate an individual's primary residence.
Adult Day Services	Services furnished in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service. The service is reimbursed at two levels: the basic rate and the enhanced rate. The enhanced rate is authorized only when staff time is needed to care for participants who demonstrate ongoing behavioral patterns that require additional prompting and/or intervention. Such behaviors include those which might result from an acquired brain injury. The behavior and need for intervention must occur at least weekly. This service is not available to persons residing in Assisted Living. The meals provided as part of this service are only provided when the participant is at the Adult Day Care Center. The cost of such meals is rolled into the Adult Day Care provider's reimbursement

DSHP-Plus HCBS Service Definitions

HCBS Service	Service Definition
	rate. The provider does not bill separately for the meal.
Day Habilitation	Day Habilitation includes assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Day habilitation services focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the service plan. In addition, day habilitation services may serve to reinforce skills or lessons taught in other settings. This service is provided to participants who demonstrate a need based on cognitive, social, and/or behavioral deficits such as those that may result from an acquired brain injury. This service is not available to persons residing in Assisted Living.
Cognitive Services	Cognitive Services are necessary for the assessment and treatment of individuals who exhibit cognitive deficits or maladaptive behavior, such as those that are exhibited as a result of a brain injury. This service is not available to persons residing in Assisted Living and Nursing Facilities. Cognitive services are limited to twenty (20) visits per year plus an assessment. The managed care organization may authorize service request exceptions above this limit. Cognitive Services include two key components: • Multidisciplinary Assessment and consultation to determine the participant's level of functioning and service needs. This Cognitive Services component includes neuropsychological consultation and assessments, functional assessment and the development and implementation of a structured behavioral intervention plan. • Behavioral Therapies include remediation, programming, counseling and therapeutic services for participants and their families which have the goal of decreasing or modifying the participant's significant maladaptive behaviors or cognitive disorders that are not covered under the Medicaid State Plan. These services consist of the following elements: Individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under state law.), services of social workers, trained psychiatric nurses, and

ATTACHMENT C

DSHP-Plus HCBS Service Definitions

HCBS Service	Service Definition
	other staff trained to work with individuals with psychiatric illness, individual activity therapies that are not primarily recreational or diversionary, family counseling (the primary purpose of which treatment of the individual's condition) and diagnostic services.
Personal Emergency Response System	A Personal Emergency Response System (PERS) is an electronic device that enables a waiver participant to secure help in an emergency. As part of the PERS service, a participant may be provided with a portable help button to allow for mobility. The PERS device is connected to the participant's phone and programmed to signal a response center and/or other forms of assistance once the help button is activated. This service is not available to persons residing in Assisted Living.
Support for Participant Direction	DSHP-Plus members may opt to self-direct their Personal Care/Attendant services. Support for Participant Direction combines two functions: financial management services (FMS) and information and assistance in support of participant direction (support brokerage). Providers of Support for Participant Direction carry out activities associated with both components. The Support for Participant Direction service provides assistance to participants who elect to self-direct their personal care services. Participant direction affords DSHP-Plus members the opportunity to have choice and control over how personal care services are provided and who provides the services. Member participation in participant direction is voluntary. Members may participate in or withdraw from participant direction at any time. To the extent possible, the member shall provide his/her personal care provider ten (10) days advance notice regarding his/her intent to withdraw from participant direction. Providers of this service perform various functions to support participants in planning for and carrying out their responsibilities as common-law employers of personal care attendants. (A) **Financial Management Services.** Financial management services provide assistance to members with managing funds associated with the services elected for self-direction. The following supports are provided • Assist participants in verifying personal care attendant's citizen status • Collect and process personal care attendants' timesheets • Process payroll, withholding, filing and payment of applicable federal, state, and local employment-related taxes and insurance • Execute and hold Medicaid provider

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DSHP-Plus HCBS Service Definitions

HCBS Service	Service Definition
	agreements • Receive and disperse funds for the payment of services to personal care attendants (B) **Support Brokerage.** Support Brokerage service offers the following support: • Coordinate with participants to develop, sign, and update individual service plans • Recruit personal care attendants • Maintain a roster of personal care attendants • Secure background checks on prospective personal care attendants on behalf of participants • Provide information on employer/employee relations • Provide training to participants and personal care attendants • Provide assistance with problem resolution • Maintain participant files • Provide support in arranging for emergency back-up care
Independent Activities of Daily Living (Chore) Services	Chore services constitute housekeeping services that include assistance with shopping, meal preparation, light housekeeping, and laundry. This is an in-home service for frail older persons or adults with physical disabilities. The service assists them to live in their own homes as long as possible. The service must be provided by trained housekeepers. This service is not available to persons residing in Assisted Living.
Nutritional Supports	Nutritional supports for individuals diagnosed with AIDS that are not covered under the state plan. This service is for individuals diagnosed with HRD/AIDS to ensure proper treatment in those experiencing weight loss, wasting, malabsorption and malnutrition. Such oral nutritional supplements are offered as a service to those identified at nutritional risk. This service covers supplements not otherwise covered under the state plan service. This service does not duplicate a service provided under the state plan as an EPSDT service. Prior authorized by CM. Service must be prior authorized by case manager in conjunction with the consultation of a medical professional's recommendation for service. Standard for assessing the nutritional risk factors: • Weighing less than 90% of usual body weight; • Experiencing weight loss over a one to six month period; • Losing more than five pounds within a preceding month; • Serum albumin is less than 3.2 or very high indicating dehydration, difficulty swallowing or chewing, or

ATTACHMENT C

DSHP-Plus HCBS Service Definitions

HCBS Service	Service Definition
	persistent diarrhea; or • Wasting syndrome affected by a number of factors including intake, nutrient malabsorption & physiological and metabolic changes.
Specialized Medical Equipment and Supplies	Specialized medical equipment and supplies not covered under the Medicaid State Plan. This service includes: (a) devices, controls, or appliances specified in the plan of care that enable the member to increase his/her ability to perform activities of daily living; (b) devices, controls, or appliances that enable the member to perceive, control, or communicate with the environment in which he/she lives; (c) items to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the state plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the state plan. Items reimbursed under DSHP-Plus are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the member. This service does not duplicate a service provided under the state plan as an EPSDT service.
Minor Home Modifications	Minor home modifications are funded up to $6,000 per project; $10,000 per benefit year; and $20,000 per lifetime. The contractor case manager may authorize service request exceptions above this limit when it determines the expense is cost-effective. This service is not available to persons residing in Assisted Living. Provision and installation of certain home mobility aids (e.g., a wheelchair ramp and modifications directly related to and specifically required for the construction or installation of the ramp, hand rails for interior or exterior stairs or steps, grab bars and other devices) and minor physical adaptations to the interior of a member's place of residence which are necessary to ensure the health, welfare and safety of the individual, or which increase the member's mobility and accessibility within the residence, such as widening of doorways or modification of bathroom facilities. Excluded are installation of stairway lifts or elevators and those adaptations which are considered to be general maintenance of the residence or which are considered improvements to the residence or which are of general utility and not of direct medical or remedial benefit to the individual, such as installation, repair, replacement or roof, ceiling, walls, or carpet or other flooring; installation, repair, or replacement of heating or cooling units or systems; installation or purchase of air or water purifiers or humidifiers; and installation or repair of driveways, sidewalks,

ATTACHMENT C

DSHP-Plus HCBS Service Definitions

HCBS Service	Service Definition
	fences, decks, and patios. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.
Home Delivered Meals	Home-delivered meals (up to 1 meal per day). Nutritionally well-balanced meals, other than those provided under Title III C-2 of the Older Americans Act or through SSGB funds, that provide at least one-third but no more than two-thirds of the current daily Recommended Dietary Allowance (as estimated by the Food and Nutrition Board of Sciences – National Research Council) and that will be served in the enrollee's home. Special diets shall be provided in accordance with the individual Plan of Care when ordered by the enrollee's physician. These meals are delivered to the participant's community residence and not to other setting, such as Adult Day Programs or Senior Centers. The contractor must coordinate the delivery of these meals with staff within the Division of Services for Aging & Adults with Physical Disabilities (DSAAPD) that authorize home-bound meals utilizing Title III (Older Americans Act) and Social Service Block Grant (SSBG) funds.

ATTACHMENT E

Level of Care Criteria

I. Critical Events or Incidents

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

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

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

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

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

In Delaware, a critical event or incident is referred to as an "incident" under DLTCRP's Investigative Protocol. Under Delaware law, an incident can be defined

as anything that has a negative outcome on the resident. For APS, critical events or incidents (as defined in Title 31, Chapter 39 §3910) include abuse, mistreatment, exploitation, and neglect. In addition, APS investigates cases of inadequate self-care (self-neglect) and disruptive behavior.

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

II. Member Training and Education

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

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

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

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

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

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

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

IV. Quality Oversight and Improvement

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

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

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

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

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

Lastly, the MCO case managers can refer member concerns about provider agencies to the Division of Public Health (for licensing issues), or to the DMMA

SUR Unit (for fraud and billing irregularities).

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

Medical Eligibility Determinations

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

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

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

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

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

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Level of Care Criteria

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

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

Pre-Admissions Screening and Resident Reviews (PASRR)

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

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

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

- **Determination is made regarding the need for a Level II PASRR screening.**
  No further evaluation is needed, if, based on the Level I screening, the individual will meet one of three categories:
  - No indication of mental illness/mental retardation/related condition – nursing home admission/continued stay is appropriate - No further evaluation is needed.
  - There are indicators of mental illness/mental retardation/related condition however individual meets any of the following Physician's Exemption Criteria:

ATTACHMENT E

Level of Care Criteria

- Primary Diagnosis of Dementia or related disorder.
- Convalescent Care not to exceed 30 days - PAS nurses will track this exemption and initiate Level II PASRR evaluation prior to expiration if continued NF stay is warranted.
- Terminal Illness – a life expectancy of 6 months or less if the illness runs its normal course.
- Medical dependency with a severe physical illness.

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