DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

FINAL

ORDER

Elderly and Disabled Waiver Provider Policy Manual

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance initiated proceedings to amend the Elderly and Disabled Waiver Provider Policy Manual regarding Patient Pay Calculations, *specifically, as it relates to Home and Community-Based Services Settings*. The Department's proceedings to amend its regulations were initiated pursuant to 29 Delaware Code Section 10114 and its authority as prescribed by 31 Delaware Code Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 Delaware Code Section 10115 in the February 2017 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by March 3, 2017 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

The purpose of this notice is to advise the public that Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) is proposing to amend the Elderly and Disabled Waiver Provider Policy Manual, specifically, *as it relates to Home and Community-Based Services Settings.*

Statutory Authority

- 42 CFR §441.530; *Home and Community-Based Settings*
- 42 CFR §441, Subpart G; *Home and Community-Based Services, Waiver Requirements*
- §1915(c) of the Social Security Act; *Home and Community-Based Services*

Background

The Centers for Medicare and Medicaid Services (CMS) published regulations in the Federal Register on January 16, 2014, effective March 17, 2014, which changed the definition of Home and Community-Based Services (HCBS) settings. Delaware's 1115 Demonstration refers to the 1915(c) authority for HCBS services; therefore, the state must comply with these regulatory changes. The final rule provides for a five-year transition process that will allow states to implement this rule in a manner that supports continuity of services for Medicaid recipients and minimizes disruptions in service during implementation. Additionally, the HCBS Final Rule defines the qualities that must be present in all HCBS settings. It also provides expanded and more detailed guidance regarding the provision of HCBS, in particular the right for HCBS recipients to have the ability to exercise personal choice in all aspects of their care. In order to ensure compliance with all requirements of the HCBS Final Rule, DMMA has incorporated these requirements into our Long Term Care Community Services (LTCCS) Provider Policy. All states are required to be fully compliant with all of the requirements of the CMS HCBS Final Rule by March 17, 2019.

Summary of Proposal

Purpose

The purpose of this proposed rule is to revise Delaware's Elderly and Disabled Waiver Provider Policy Manual to include all of the mandatory provisions of the Centers for Medicare & Medicaid Services (CMS) Home and Community Based Services (HCBS) Final Rule.

Public Notice

In accordance with the *federal* public notice requirements established at Section 1902(a)(13)(A) of the Social Security Act and 42 CFR 447.205 and the *state* public notice requirements of Title 29, Chapter 101 of the Delaware Code, Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) gives public notice and provides an open comment period for thirty (30) days to allow all stakeholders an opportunity to provide input on the revision of the Elderly and Disabled Waiver Provider Policy Manual. Comments must be received by 4:30 p.m. on March 3, 2017.

Provider Manuals Update

Also, there may be additional provider manuals that will require small updates as a result of these changes. The applicable Delaware Medical Assistance Program (DMAP) Provider Policy Specific Manuals will be updated. Manual updates, revised pages or additions to the provider manual are issued, as required, for new policy, policy clarification, and/or revisions to the DMAP program. Provider billing guidelines or instructions to incorporate any new requirement may also be issued. A newsletter system is utilized to distribute new or revised manual material and to provide any other pertinent information regarding manual updates. DMAP provider manuals and official notices are available on the Delaware Medical Assistance Provider Portal website**:** https://medicaid.dhss.delaware.gov/provider

Fiscal Impact

No fiscal impact is projected as this regulation is only updating the language in Delaware's Elderly and Disabled Waiver Provider Policy Manual to reflect current practices.

Summary of Comments Received with Agency Response and Explanation of Changes

The State Council for Persons with Disabilities (SCPD) and the Governor's Advisory Council for Exceptional Citizens (GACEC) offered the following summarized observations:

The primary impetus for the revisions is to promote conformity with the CMS HCBS settings rule. Overall, the initiative mirrors CMS standards and provides helpful, affirmative guidance to MCOs and providers.

First, DMMA provided an early draft of the revised policy to the DLP in December, 2015 which prompted the DLP to share 3 pages of recommendations in January, 2016. The current draft reflects approximately nine (9) amendments based on the recommendations.

Agency Response: DMMA is grateful for the suggestions provided by the DLP in January, 2016. We thank the Council for noticing that we adopted many of the suggestions made by the DLP in this final draft of the revised manual.

Second, the Elderly and Disabled Waiver no longer exists. It was merged into the DSHP+ program in 2012. See, e.g., attached excerpt from DMMA May 18, 2011 overview. See also §1.0, deleting reference to E&D waiver. The title to the Provider Manual should therefore be revised. Consistent with §1.0, the following title could be considered: "Long Term Care Community Services (LTCCS) Provider Policy Manual" or "Long Term Care Community Services/Diamond State Health Plan Plus Provider Policy Manual".

Agency Response: DMMA did revise the title of this manual along with its content. The correct title of the revised manual is the Long Term Care Community Services (LTCCS) Provider Policy Manual.

Third, §2.2.1 does not match the formatting in the balance of the section and is merely a non-directive statement. Consider the following substitute:

> 2.2.1. The LTCCS setting must be integrated and support full access of LTCCS recipients to the greater community, including:...

Agency Response: DMMA appreciates the Council's suggestion. However, we intentionally used the exact wording from 42 CFR §441.530(a)(1)(i) in order to demonstrate our intent to comply fully with all requirements outlined in the federal regulation to CMS. §2.2 Requirements for LTCCS Provider Settings provides the context for the language contained in §2.2.1.

Fourth, §§2.2.6 and 2.2.7 recite that recipients "should" have the freedom and support to control their own schedules... and be able to have visitors of their choosing at any time. This is not co-terminus with the federal regulation, 42 C.F.R. 441.530, which recites that states "must" make available a list of supports, including the following:

Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.

Individuals are able to have visitors of their choosing at any time.

For consistency with §§2.2.2-2.2.5, DMMA may wish to use the term "must" rather than "should", i.e., "individuals must have the freedom" and "individuals must be able to have visitors...".

Agency Response: DMMA agrees with this important distinction in terminology in §§2.2.6-2.2.7. We will revise the identified sections in accordance with the Council's recommendations as follows:

> 2.2.6 Recipients ~~should~~ must have the freedom and support to control their own schedules and activities, and have access to food at any time.

> 2.2.7 Recipients ~~should~~ must be able to have visitors of their choosing at any time.

Fifth, §3.1.5 requires providers to provide DHSS with access to participant records. DMMA may wish to consider adding a provision addressing access by DHSS authorized representatives to provider-owned or leased settings (e.g. day

habilitation; adult day services) in which covered services are provided. This is a DHSS statutory right for licensed residential LTC facilities. See Title 16 Del.C. §1105(a)(5), 1107 and 1134(d)(11). However, day programs are not covered by the residential LTC statutes so DHSS may wish to include the right in the policy manual.

Agency Response: DMMA appreciates the Council's suggestion; however, no changes have been made to the provider manual.

Sixth, DMMA should correct the grammar in §3.3.2.6. The section recites that the person centered planning process is required to include nine (9) listed features. All of the items in the list begin with a verb. Subsection 3.3.2.6 is inconsistent. See Delaware Legislative Drafting Manual, Rule 27, published at http://legis.delaware.gov/docs/default-source/Publications/legislative-drafting-manual.pdf?sfvrsn=4

Agency Response: DMMA agrees with the Council's findings. The final regulation will be revised as follows:

> 3.3.2.6 Precludes providers of HCBS for the recipient, or those who have an interest in or are employed by a provider of HCBS for the recipient, from providing case management or developing the person-centered service plan.

Seventh, in §3.4.2, DMMA should consider replacing "authority" with "authorities" since there may be more than 1 entity to which critical incidents must be reported. For example, the DHSS PM 46 policy, §V.K.2 (Rev. 8/16) contemplates covered entities reporting to both the police and DHSS for conduct amounting to a crime. There is also overlapping jurisdiction between the Ombudsman (§3.4.2.2.2) and DLTCRP (§3.4.2.2.3).

Agency Response: DMMA agrees with the Council's suggested revision. The final regulation will be revised as follows:

> 3.4.2 All parties have the responsibility to report critical incidents in accordance with State laws, rules, regulations and agency policy memorandums to the appropriate investigative authorities immediately upon discovery.

Eighth, §§3.4.2.2.3 and 3.4.2.2.4 merit review. I understand that licensing of acute and outpatient health care was switched when the DPH OHFLC was placed under the DLTCRP effective July 1, 2016. See http://www.dhss.delaware.gov/dhss/dltcrp/

Agency Response: DMMA thanks the Council for this comment. The final regulation will be revised as follows:

> 3.4.2.2.3 Division of Long Term Care and Residents Protection (DLTCRP) for recipients receiving services in a long term care facility and there is an incident of abuse, neglect, or mistreatment, and/or financial exploitation. DLTCRP is also the designated agency to regulate acute and outpatient health care facilities/agencies and to receive Critical Incidents occurring in these facilities involving abuse, neglect or harassment; hospital, hospice seclusion and restraint deaths. Reports of suspected abuse, neglect, and exploitation of recipients who are children residing in pediatric nursing facilities must also be reported to DLTCRP.
>
> 3.4.2.2.4 Office of Health Facilities Licensing and Certification (OHFLC) is the designated agency to regulate acute and outpatient health care facilities/agencies and receives Critical Incidents occurring in these facilities involving abuse, neglect or harassment; hospital, hospice seclusion and restraint deaths.

Ninth, DMMA may wish to add a reference to the requirement of critical incident reporting concerning patients of psychiatric hospitals and residential centers to the Protection & Advocacy agency pursuant to 16 **Del.C.** §5162. See also DHSS PM 46 policy, §V.K.2 (Rev. 8/16).

Agency Response: DMMA thanks the Council for this suggestion. We feel that the content of 3.4.2 provides the regulatory framework to cover critical incident reporting for LTCCS providers in accordance with all State laws, rules, regulations, etc.

Tenth, §6.2, entitled "Available Services", omits some services included in the MCO contract, including minor home modifications, home-delivered meals, transition services, and nutritional supplements. Each of these services enhance community-based living as much as the listed personal emergency response system. DMMA should consider adding the omitted services.

Agency Response: DMMA appreciates the Council's suggestion; however, no changes have been made to the provider manual.

Eleventh, §6.2.1 and 6.2.2 contain specific references to additional services for individuals with brain injuries in the contexts of adult day services and attendant services:

Members with an acquired brain injury (ABI) or traumatic brain injury (TBI) will receive additional prompting and/or intervention as needed, and as indicated in the person-centered service plan.

Agency Response: DMMA thanks the Council for this observation. This language is consistent with requirements on person-centered planning detailed elsewhere in this policy manual and extensively in our MCO contract.

Councils endorse the proposed regulation.

Agency Response: DMMA thanks the Council for its endorsement of the proposed regulation.

Thank you again for your review and feedback related to the proposed revisions to the Long Term Care Community Services (LTCCS) Provider Policy Manual. DMMA is pleased to provide the opportunity to receive public comments and greatly appreciates the thoughtful input given.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the February 2017 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend the Elderly and Disabled Waiver Provider Policy Manual, specifically, *as it relates to Home and Community-Based Services Settings,* is adopted and shall be final effective May 11, 2017.

Kara Odom Walker, MD, MPH, MSHS
Secretary, DHSS

DMMA FINAL ORDER APA 17-016
REVISION

1.0 Overview

Health care services are provided to ~~the majority of Medicaid clients~~ Long Term Care Community Services (LTCCS) recipients through a Managed Care Organization (MCO). ~~Elderly and Disabled Waiver (E and D) Waiver services are included in the MCO benefits package. All Elderly and Disabled Waiver clients who are enrolled with an MCO must receive E and D Waiver services through the MCO.~~ Enrollment in a MCO is required in order for clients to receive services through the LTCCS program.

1.1 ~~Waiver~~ LTCCS Objectives

1.1.1 The LTCCS program provides for home and community-based services in integrated community settings for ~~individuals aged 18 and above~~ recipients who are elderly, ~~or who~~ have physical disabilities (including acquired brain injuries), certain diagnoses (including Acquired Immune Deficiency Syndrome (AIDS) or HIV-Related Diseases), or reside in Assisted Living (AL) facilities and who have limited ability to perform activities of daily living and would ~~otherwise require care in a nursing facility~~ be "at risk" of requiring nursing facility placement in the absence of LTCCS.

1.1.2 The goal of the waiver is to provide services to persons in a manner which responds to each participant's abilities, assessed needs, and preferences, and ensures maximum self-sufficiency, independent functioning, and safety in the most integrated community-based settings while preserving recipient dignity, respect and privacy. This goal is accomplished through the delivery of a range of home and community-based long-term care services which target the special needs of the population.

1.2 Program Description

1.2.1 The ~~Elderly and Disabled (E&D) Waiver is a~~ LTCCS program is operated and administered by the Division of ~~Services for Aging and Adults with Physical Disabilities (DSAAPD). The Division of~~ Medicaid and Medical Assistance (DMMA). ~~has oversight responsibilities, DSAAPD and DMMA share responsibilities for determining eligibility for waiver program applicants~~ DMMA contracts with Managed Care Organizations (MCOs) which are responsible for delivery of LTCCS to eligible and enrolled program participants.

1.2.2 Participants who are eligible for this program can receive, as needed, all regular Medicaid services AND additional ~~Waiver~~ LTCCS services that Medicaid normally does not cover.

2.0 ~~Program/Contractual Responsibilities~~ Qualities of LTCCS Provider Settings

2.1 ~~Elderly & Disabled Waiver Provider Responsibilities~~ Overview

2.1.1 All LTCCS provider settings must be fully compliant with the requirements set forth in 42 CFR §441.301(c)(4). DMMA will be unable to contract with noncompliant LTCCS providers for the delivery of LTCCS after March 17, 2019.

~~2.1.1 The E&D provider must agree to all terms and conditions listed in the Delaware Medical Assistance Program (DMAP) contract and the policies and procedures of DMAP.~~

~~2.1.2 The E&D provider must meet and comply with DSAAPD Service Specifications for services delivered. Waiver program service specifications can be found at: http://www.dhss.delaware.gov/dhss/dsaapd/waiver_service_specifications.html~~

~~2.1.3 The E&D provider must meet and comply with all federal, state and local rules, regulations, and standards that are applicable to the services rendered.~~

~~2.1.4 The E&D provider must consider all referred waiver participants for placement.~~

~~2.1.5 The E&D provider must maintain participant confidentiality.~~

~~2.1.6 The E&D provider must ensure access to participant's case records by authorized representatives of Delaware Health and Social Services and/or the Center for Medicare and Medicaid Services (CMS).~~

~~2.1.7 The E&D provider must ensure that participants who have grievances or complaints receive a timely hearing and response and that, whenever possible, participants' grievances and complaints are resolved to his/her satisfaction. A written record of all such grievances and complaints must be maintained by the E&D provider.~~

~~2.1.8 The E&D provider must provide notice to the DSAAPD and DMMA when changes, such as the following occur:~~

~~2.1.8.1 A change in ownership, including a change in the membership of boards of directors or other corporate governing bodies.~~

~~2.1.8.2 A change in the provider agency's director.~~

~~2.1.8.3 Any change in the form of legal organization of the provider agency.~~

~~2.1.8.4 At least 60 days advance notice for planned changes, and immediate notification when unforeseen changes occur, is required. Contracts with E&D waiver providers may not be transferred; when a change in ownership or corporate structure occurs, DMMA will determine if a new contract must be negotiated with the E&D provider.~~

~~2.1.9 The E&D provider must accept the reimbursement rates published by DSAAPD as payment in full for each participant the E&D provider admits.~~

~~2.1.10 In the event that the E&D provider contract is terminated, DSAAPD will retain, without cost, ownership of all case records maintained by the E&D provider. Upon written request from DSAAPD, the E&D provider agrees to provide copies of all case records within fifteen days of receipt of the termination notice.~~

2.2 ~~Division of Services for Aging & Adults with Physical Disabilities (DSAAPD) Responsibilities~~ Requirements for LTCCS Provider Settings

2.2.1 ~~DSAAPD agrees to furnish the E&D provider with administrative and program guidance.~~ The setting is integrated in and supports full access of LTCCS recipients to the greater community, including:

2.2.1.1 Opportunities to seek employment and work in competitive integrated settings;

2.2.1.2 Opportunities to engage in community life;

2.2.1.3 Opportunities to control personal resources;

2.2.1.4 Opportunities to receive services in the community, to the same degree of access as recipients not receiving Medicaid HCBS.

2.2.2 ~~DSAAPD agrees to identify a Community Services Program (CSP) contact for the service area of the waiver provider.~~ The setting must optimize, but not regiment, recipient initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

2.2.3 ~~If the applicant or participant requests a fair hearing, DSAAPD agrees to make arrangements to provide such a hearing through its normal fair hearing procedures.~~ The setting must ensure a recipient's rights of privacy, dignity and respect, and freedom from coercion and restraint.

2.2.4 The setting must facilitate recipient choice regarding services and supports, and who provides them.

2.2.5 The setting must be physically accessible.

2.2.6 Recipients **[~~should~~ must]** have the freedom and support to control their own schedules and activities, and have access to food at any time.

2.2.7 Recipients **[~~should~~ must]** be able to have visitors of their choosing at any time.

2.3 ~~Responsibilities of Both Parties~~ Requirements Specific to Provider-Owned or Controlled Residential Settings

2.3.1 ~~Formal communication concerning the contract, program activities, treatment methods, and reports, etc. will be made via written correspondence between the E&D waiver provider and the DSAAPD.~~ In addition to

the requirements listed above in 2.1 and 2.2, provider-owned or controlled residential settings must also meet the following conditions:

2.3.1.1 The unit or dwelling must be a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the recipient receiving services, and the recipient has, at a minimum, the same responsibilities and protections from eviction that tenants have under 25 Del.C Part III-Residential Landlord-Tenant Code.

2.3.1.2 Each recipient must have privacy in their sleeping or living unit.

2.3.1.2.1 Units have entrance and bathroom doors lockable by the recipient, with only appropriate staff having keys to doors.

2.3.1.2.2 Recipients who share units must have a choice of roommates in that setting.

2.3.1.2.3 Recipients must be given the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

2.3.2 Modifications to Requirements

2.3.2.1 Any modification of the conditions set forth in this chapter must be supported by a specific assessed need and justified in the person-centered service plan (see section 3.3.3 of this manual).

2.4 Settings That Are Not LTCCS

2.4.1 LTCCS settings do not include the following:

2.4.1.1 A nursing facility (NF);

2.4.1.2 An institution for mental diseases (IMD);

2.4.1.3 An intermediate care facility for individuals with intellectual disabilities (ICF/IID);

2.4.1.4 A hospital; or

2.4.1.5 Any other locations that have qualities of an institutional setting, as determined by DMMA. This would include any other settings that have the effect of isolating recipients receiving Medicaid LTCCS from the broader community of recipients not receiving Medicaid LTCCS.

3.0 Program ~~Eligibility Criteria/~~Contractual Responsibilities

3.1 ~~Criteria~~ LTCCS Provider Responsibilities

3.1.1 ~~In order to participate in the E&D waiver program, an individual must meet medical and financial criteria as established in Appendix B of the approved E&D waiver application.~~ The LTCCS provider must agree to all terms and conditions listed in the Delaware Medical Assistance Program (DMAP) contract, the MCO contract, and the policies and procedures of the DMAP and the MCO.

~~3.1.1.1 The approved E&D waiver application can be found on the Publications page of the DSAAPD website: http://www.dhss.delaware.gov/dhss/dsaapd/publica.html~~

~~3.1.1.2 Determination of waiver eligibility is the responsibility of state staff.~~

3.1.2 The LTCCS provider must meet and comply with all federal, state and local rules, regulations and standards that are applicable to the services rendered.

3.1.3 The LTCCS provider must consider all referred LTCCS participants for covered services.

3.1.4 The LTCCS provider must maintain participant confidentiality.

3.1.5 The LTCCS provider must ensure access to participants' case records by authorized representatives of Delaware Health and Social Services (DHSS), the MCO, and/or the Center for Medicare and Medicaid Services (CMS).

3.1.6 The LTCCS provider must ensure that participants who have grievances or complaints receive a timely hearing and a written response. Whenever possible, participants' grievances and complaints should be resolved to the participant's satisfaction. A written record of all such grievances and complaints must be maintained by the LTCCS provider.

3.1.7 The LTCCS provider must provide notice to the DMMA and MCO when changes, such as the following, occur:

3.1.7.1 A change in ownership, including a change in the membership of boards, directors, or other corporate governing bodies.

3.1.7.2 A change in the provider agency's director.

3.1.7.3 Any change in the form of legal organization of the provider agency.

3.1.7.4 At least sixty (60) days advance notice for planned changes, and immediate notification when unforeseen changes occur, is required. Contracts with LTCCS providers may not be transferred; when a change in ownership or corporate structure occurs, DMMA will determine if a new contract must be negotiated with the LTCCS provider.

3.1.8 The LTCCS provider must accept the reimbursement rates published by DMMA as payment in full for each participant the LTCCS provider serves.

3.1.9 In the event that the LTCCS provider contract is terminated, by either DMMA or the MCO, the provider will retain, without cost, ownership of all case records maintained by the LTCCS provider. Upon written request, the LTCCS provider agrees to provide copies of all case records within fifteen (15) days of receipt of the termination notice.

3.2 DMMA Responsibilities

3.2.1 DMMA agrees to furnish the MCO and LTCCS providers with administrative, policy and program guidance.

3.2.2 If the applicant or participant requests a fair hearing, DMMA agrees to make arrangements to provide such a hearing through its normal fair hearing procedures.

3.3 MCO Responsibilities

3.3.1 Contracted MCOs agree to abide by all terms and conditions set forth in their contract with DMMA.

3.3.2 In accordance with 42 CFR §441.301(c)(1), the MCO is required to utilize a person-centered planning process for all LTCCS recipients. The LTCCS recipient will lead the person-centered planning process, where possible, with the LTCCS recipient's representative having a participatory role, as needed and as defined by the recipient. The person-centered planning process:

3.3.2.1 Includes people chosen by the recipient.

3.3.2.2 Provides necessary information and support to ensure that the recipient directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

3.3.2.3 Is timely and occurs at times and locations of convenience to the recipient.

3.3.2.4 Reflects cultural considerations of the recipient and is conducted by providing information in plain language and in a manner that is accessible to recipients with disabilities and recipients with limited English proficiency.

3.3.2.5 Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

3.3.2.6 **[~~Providers of HCBS for the recipient, or those who have an interest in or are employed by a provider of HCBS for the recipient must not provide case management or develop the person-centered service plan.~~ Precludes providers of HCBS for the recipient, or those who have an interest in or are employed by a provider of HCBS for the recipient, from providing case management or developing the person-centered service plan.]**

3.3.2.7 Offers informed choices to the recipient regarding the services and supports they receive and from whom, including the option to choose from among both residential and day settings, including generic settings.

3.3.2.8 Includes a method for the recipient to request updates to the plan as needed.

3.3.2.9 Records the alternative home and community-based settings that were considered by the recipient.

3.3.3 In accordance with 42 CFR §441.301(c)(2) and (3), the MCO is required to complete a person-centered service plan for each LTCCS recipient. The person-centered service plan must reflect the services and supports that are important for the recipient to meet the needs identified through an assessment of functional need, as well as what is important to the recipient with regard to preferences for the delivery of such services and supports. The person-centered service plan must be reviewed, and revised upon reassessment of functional need, at least every twelve (12) months, when the recipients circumstances or needs change significantly, or at the request of the recipient. The written plan must:

3.3.3.1 Reflect that the setting in which the recipient resides is chosen by the recipient. Recipients must also be given the opportunity to choose a private unit in a residential setting. The State must ensure that the setting chosen by the recipient is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

3.3.3.2 Reflect the individual's strengths and preferences.

3.3.3.3 Reflect clinical and support needs as identified through an assessment of functional need.

3.3.3.4 Include individually identified goals and desired outcomes.

3.3.3.5 Reflect the services and supports (both paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports.

3.3.3.6 Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

3.3.3.7 Be understandable to the individual receiving services and supports, and the individuals important in supporting the recipient. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR §435.905(b).

3.3.3.8 Identify the individual and/or entity responsible for monitoring the plan.

3.3.3.9 Be finalized and agreed to, with the informed consent of the recipient in writing, and signed by all individuals and providers responsible for its implementation.

3.3.3.10 Be distributed to the recipient and other people involved in the plan.

3.3.3.11 Include those services, the purpose or control of which the recipient elects to self-direct.

3.3.3.12 Prevent the provision of unnecessary or inappropriate services and supports.

3.3.3.13 Document that any modification of the conditions listed under subsection 2.2 of this manual, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

3.3.3.13.1 Identify a specific and assessed need.

3.3.3.13.2 Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

3.3.3.13.3 Document less intrusive methods of meeting the need that have been tried but did not work.

3.3.3.13.4 Include a clear description of the condition that is directly proportionate to the specific assessed need.

3.3.3.13.5 Include a regular collection and review of data to measure the ongoing effectiveness of the modification.

3.3.3.13.6 Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

3.3.3.13.7 Include informed consent of the recipient.

3.3.3.13.8 Include an assurance that interventions and supports will cause no harm to the recipient.

3.4 Responsibilities of All Parties

3.4.1 Formal communication concerning the contract, program activities, treatment methods, and reports, etc. will be made via written correspondence between DMMA, the MCO and the LTCCS provider.

3.4.2 All parties have the responsibility to report critical incidents in accordance with State laws, rules, regulations and agency policy memorandums to the appropriate investigative **[~~authority~~ authorities]** immediately upon discovery. Reporting responsibilities include the requirement to contact 9-1-1 in emergency or potentially life-threatening situations involving HCBS recipients and to report crimes committed against HCBS recipients.

3.4.2.1 Critical incidents include, but are not limited to:

3.4.2.1.1 Deaths

3.4.2.1.2 Suspected abuse/neglect/exploitation

3.4.2.1.3 Serious illness

3.4.2.1.4 Injury to recipient

3.4.2.1.5 Deliberate damage to recipient's property or theft

3.4.2.1.6 Medication management issues (errors, omissions, etc.)

3.4.2.1.7 Other high risk incidents including, but not limited to environmental hazards, suicide threats, self-injurious behaviors, etc.

3.4.2.2 Critical incidents will be reported to the appropriate agency in accordance with the following:

3.4.2.2.1 Adult Protective Service (APS) for suspected abuse, inadequate self-care, neglect, disruptive behavior and exploitation.

3.4.2.2.2 DHSS Long Term Care Office of the State Ombudsman (OSO) for residents of a long term care facility who have a complaint about their rights.

3.4.2.2.3 Division of Long Term Care and Residents Protection (DLTCRP) for recipients receiving services in a long term care facility and there is an incident of abuse, neglect, or mistreatment, and/or financial exploitation. **[DLTCRP is also the designated agency to regulate acute and outpatient health care facilities/agencies and to receive Critical Incidents occurring in these facilities involving abuse, neglect or harassment; hospital, hospice seclusion**

and restraint deaths.] Reports of suspected abuse, neglect, and exploitation of recipients who are children residing in pediatric nursing facilities must also be reported to DLTCRP.

3.4.2.2.4 **[~~Office of Health Facilities Licensing and Certification (OHFLC) is the designated agency to regulate acute and outpatient health care facilities/agencies and receives Critical Incidents occurring in these facilities involving abuse, neglect or harassment; hospital, hospice seclusion and restraint deaths.~~**

~~3.4.2.2.5~~] The Division of Family Services (DFS): is the designated agency to receive, investigate, and respond to Critical Incidents of abuse or neglect of children living in the community.

4.0 ~~Application~~ Program Eligibility Criteria

4.1 ~~Application Instructions~~ Criteria

4.1.1 ~~An individual wishing to apply for the E&D Waiver must contact the appropriate DSAAPD Community Services Program Unit to initiate the application. Refer to Section 9.0 of this manual for the appropriate Community Service Program Unit address and phone number.~~ In order to participate in the LTCCS program, an individual must meet medical and financial criteria as established by DMMA.

4.1.1.1 The LTCCS application may be requested by contacting the DMMA Central Intake Unit (CIU). Refer to Section 7.0 of this manual for DMMA CIU contact information.

4.1.1.2 Determination of LTCCS eligibility is the responsibility of DMMA staff.

5.0 ~~Content/Description of Services~~ Application

5.1 ~~Limitations~~ Application Instructions

5.1.1 ~~The services provided to eligible persons may be limited in duration or amount as documented in Appendix C of the E&D Waiver application.~~ An individual who wishes to apply for the LTCCS program must contact the DMMA CIU to initiate the application. Refer to Section 7.0 of this manual for the DMMA CIU contact information.

6.0 Content/Description of Services

6.1 Scope of Services

6.1.1 The MCO shall furnish covered services in an amount, duration and scope that is no less than the amount, duration and scope for the same benefit/service as specified in Delaware's Medicaid State Plan.

~~5~~6.1.2 ~~Service limitations imposed by DSAAPD staff will be consistent with the medical necessity of the patient's condition, as determined by the DSAAPD Case Manager and DSAAPD Nurse Consultant with the assistance of the attending physician or other practitioner. This determination will be made in accordance with standards generally recognized by licensed health professionals and promulgated through the DSAAPD.~~ MCO determinations of amount, duration and scope of covered services shall be guided by the considerations contained in Section 13.0-Appendix H (Medical Necessity Definition) of DMMA's General Policy Manual.

~~5~~6.2 Available Services

~~5~~6.2.1 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. Members with an acquired brain injury (ABI) or traumatic brain injury (TBI), will receive additional prompting and/or intervention as needed, and as indicated in the person-centered service plan. 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. This service is not available to persons residing in assisted living or nursing facilities.

~~5~~6.2.2 ~~Personal Care~~ Attendant Services - ~~Personal~~ Attendant care services includes assistance with activities of daily living (ADL's) (bathing, dressing, personal hygiene, transferring, toileting, skin care, eating and assisting with mobility). When specified in the plan of care, this service includes assistance with instrumental activities of daily living (IADL's) (e.g. light housekeeping chores, shopping, meal preparation). Assistance with IADL's must be essential to the health and welfare of the participant. This service does not duplicate a service provided under the state plan as an expanded EPSDT service. Members with an acquired brain injury (ABI) or traumatic brain injury (TBI) will receive additional prompting and/or intervention as needed, and as indicated in the person-centered service plan. This service is not available to persons residing in assisted living or nursing facilities.

~~5~~6.2.3 Respite - Respite service provides supportive care in ~~assisted living facilities or nursing facilities~~ HCB settings on a short-term basis because of the absence of, or need for relief for, those persons normally

providing the care. This service does not duplicate a service provided under the state plan as an expanded EPSDT service.

~~5.2.3.1 The service is not available to participants whose primary residence is an assisted living facility.~~

~~5.2.3.2~~

6.2.3.1 Limit of no more than fourteen (14) days per year. Case managers prior authorize this service and may authorize service request exceptions above these limits.

~~5~~6.2.4 Personal Emergency Response System (PERS) - A PERS is an electronic device that enables an ~~waiver~~ LTCCS 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. The PERS service is available only to participants who live outside of assisted living facilities. This service does not duplicate a service provided under the state plan as an expanded EPSDT service.

~~5~~6.2.5 Specialized Medical Equipment and Supplies - Specialized medical equipment and supplies include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or 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 with waiver funds 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 participant. All items shall meet applicable standards of manufacture, design and installation. This service does not duplicate a service provided under the state plan as an expanded EPSDT service.

~~5~~6.2.6 Cognitive Services - Cognitive Services are necessary for the assessment and treatment of individuals who exhibit cognitive deficits or interpersonal conflict, such as those that are exhibited as a result of a brain injury. Cognitive Services include two key components:

~~5~~6.2.6.1 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.

~~5~~6.2.6.2 Behavioral Therapies include remediation, programming, counseling and therapeutic services for participants and their families which have the goal of decreasing or modifying the participant's significant maladaptive behaviors or cognitive disorders that are not covered under the Medicaid State Plan. These services consist of the following elements: Individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law.), services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness, individual activity therapies that are not primarily recreational or diversionary, family counseling (the primary purpose of which treatment of the individual's condition) and diagnostic services.

6.2.6.3 These services are not available to persons residing in assisted living or nursing facilities.

~~5~~6.2.7 Day Habilitation - Day Habilitation ~~service is the~~ includes assistance with ~~the~~ acquisition, reacquisition, retention, or improvement in self-help, socialization and adaptive skills that take place in a non-residential HCB 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 regiment" (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 does not duplicate a service provided under the state plan as an expanded EPSDT service.

~~5~~6.2.8 Assisted Living - Assisted Living provides personal care and supportive services (homemaker, chore, attendant services, and meal preparation) that are furnished to ~~waiver~~ LTCCS 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, the assisted living 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.

5<u>6</u>.2.9 ~~Waiver~~ LTCCS clients are also eligible for all services normally covered by the DMAP.

~~6.0 Reimbursement~~

~~6.1 General Criteria~~

~~6.1.1 The DMAP reimburses E&D providers in accordance with the federally approved E&D Waiver and the waiver program service specifications.~~

~~6.1.2 The E&D provider will not be reimbursed for extra-contractual services unless specifically authorized in writing by the DMAP. If the E&D provider furnishes such services without prior written authorization from the DMAP, these services will be deemed by the DMAP to be gratuitous and not subject to any financial reimbursement except as provided for by separate agreements.~~

~~6.1.3 It is agreed that adjustments to the per diem and monthly rates will be negotiated on a yearly basis. There will be no adjustments to the rates during the year.~~

~~6.1.4 Medicaid waiver reimbursement does not include the participant's patient pay amount.~~

~~6.1.5 Medicaid does not reimburse the assisted living provider for "bed-hold" days (e.g., a bed held for a consumer who is physically absent from the facility because of hospitalization or non-medical/social leave absence).~~

~~6.2 Assisted Living Service Supplemental Services Payment (Add-On) Overview~~

~~6.2.1 Within the Assisted Living service under the E&D Waiver there is a Supplemental Services Payment (i.e. Add-On). This additional reimbursement opportunity is offered for assisted living service participants with dementia or other cognitive impairments who have the characteristics such as those listed in Section 6.3 , may need additional staff support, intervention and supervision from the assisted living agency. E&D Assisted Living service providers that serve persons with dementia or other cognitive impairments must have the capacity to provide needed staff support, intervention and supervision to such individuals. Providers may request approval from DSAAPD to receive a supplemental payment for individual consumers, equivalent to 10% of the base payment.~~

~~6.3 Assisted Living Service Supplemental Services Payment (Add-On) Detail~~

~~6.3.1 A request for supplemental payment will be approved based on evidence that all of the conditions specified below are met.~~

~~6.3.1.1 A request for supplemental payment will be approved based on documentation presented of the participant's diagnosis of severe cognitive impairment with one or more of the characteristics specified below, as determined by a written assessment of the participant's psychosocial and cognitive status in consultation with an appropriate medical and/or mental health professional. Characteristics include, but are not limited to, the following:~~

~~6.3.1.1.1 Severe memory loss~~

~~6.3.1.1.2 Disorientation/confusion~~

~~6.3.1.1.3 Impaired judgment that significantly affects ability to recognize the need for assistance~~

~~6.3.1.1.4 Inability to recognize danger~~

~~6.3.1.1.5 Inability to communicate needs by any means or to summon assistance~~

~~6.3.1.2 Documented evidence is provided to verify that a pattern of significant behavior problems exists, that is, significant behavior problems occur frequently and/or are unpredictable. Such behaviors must be shown to have a specific impact on the health, safety and/or independent functioning of the consumer and/or the health safety, independent functioning and/or rights of other consumers, with the result that supervision is needed all or most of the time. Behaviors that may rise to the level of significant behavior problems include, but are not limited to, the following:~~

~~6.3.1.2.1 Wandering~~

~~6.3.1.2.2 Self abusive behaviors~~

~~6.3.1.2.3 Verbal aggression, e.g., cursing, threatening to strike, hit, punch, biting~~

~~6.3.1.2.4 Agitation/disruptive behavior, e.g., screaming, banging, throwing objects~~

~~6.3.1.2.5 Combative behavior/physical aggression during care or in interactions with others~~

~~6.3.1.2.6 Verbal or physical sexual advances, public masturbation~~

7.0 ~~Obtaining Prior Authorization~~ <u>Contact Information - DMMA and MCO</u>

7.1 ~~Prior Authorization Process~~ DMMA

~~7.1.1 All E&D Waiver specific services (except Assisted Living services) require prior authorization. Refer to Section 5.2 of this manual for details of the E&D Waiver services.~~

~~7.1.2 For Prior Authorization approval providers must contact the appropriate Direct Service office. See Section 9.1 of this manual for regional contact information.~~

~~7.1.3 The waiver provider will receive the prior authorization decision via a letter generated by DSAAPD.~~

~~7.1.4 To bill for E&D Waiver services: providers must utilize their National Provider Identification (NPI) number, the E&D Waiver taxonomy, the prior authorization number and the appropriate procedure code listed in Section 8.1 on all claims submitted for payment.~~

Central Intake Unit (CIU)
153 E. Chestnut Hill Road, Newark, DE 19713
Phone: 1-866-940-8963
Fax: (302)451-3628

Pre Admission Screening (PAS)

New Castle County
153 E. Chestnut Hill Road, Newark, DE 19713
Phone: (302)451-3640
Fax: (302)451-3668

Kent County
200 S. DuPont Boulevard, Suite 101, Smyrna, DE 19977
Phone: (302)514-4560
Fax: (302)514-4561

805 River Road, Dover, DE 19901
Phone: (302)857-5070
Fax: (302)857-5071

253 NE Front Street, Milford, DE 19963
Phone: (302)424-7172
Fax: (302)424-7218

Sussex County
546 S. Bedford Street, Georgetown, DE 19947
Phone: (302)515-3150
Fax: (302)515-3151

7.2 MCO

United Healthcare Community Plan (Administrative Office)
4051 Ogletown Road, Suite 200, Newark, DE 19713
Phone: 1-800-600-9007
Fax: 1-877-877-8230
www.UHCCommunityPlan.com

Highmark Health Options
800 Delaware Avenue, Wilmington, DE 19801
Phone: 1-844-325-6252
Fax: 1-855-476-4158

8.0 Procedure Codes for the Elderly & Disabled Waiver

8.1 Procedure Codes

The following procedure codes are to be used for billing services under the Elderly and Disabled Waiver.

Code	Description
S5130	Personal Care service – performed by Home Health Aide Only agency: 15 minute unit reimbursed
S5130 U1	Personal Care service – performed by PASA agency: 15 minute unit reimbursement
S5130 U2	Personal Care service – performed by Personal Attendant agency: 15 minute unit reimbursement
S9125	Respite service – Daily rate – 24 hour unit reimbursement
T2020	Day Habilitation – Daily rate for attendance at 4.5 hours and above
T2021	Day Habilitation – ½ day rate for attendance at under 4.5 hours
90801	Cognitive Services – One-time assessment reimbursement
90806	Cognitive Services – 15 minute unit therapy session
S5101	Adult Day Service (Basic) – ½ day rate for attendance under 4.5 hours
S5105	Adult Day Service (Basic) – Daily rate for attendance at 4.5 hours and above
S5101 U1	Adult Day Service (Enhanced) – ½ day rate for attendance under 4.5 hours
S5105 U1	Adult Day Service (Enhanced) – Daily rate for attendance at 4.5 hours and above
S5160	Personal Emergency Response System – Installation
S5161	Personal Emergency Response System – Monthly monitoring
S5162	Personal Emergency Response System – Extra pendant
T1005	Respite care up to 15 minutes (bill as units)
***(LOR)**	Assisted Living service is reimbursed by the waiver participants Level of Reimbursement (LOR). This level will be determined by state staff.

~~9.0 Locations and Telephone Numbers - Division of Services for Aging and Adults with Physical Disabilities (DSAAPD)~~

~~9.1 Direct Services~~

~~New Castle County~~

~~University Plaza 256 Chapman Road Oxford Building, Suite 200 Newark, DE 19702 1-800-223-9074 Fax: (302) 391-3501 Fax: (302) 391-3501 - Adult Protective Services TDD: (302) 391-3505 Kent/Sussex Counties DSAAPD Milford Office 18 N. Walnut St., First Floor Milford, DE 19963 1-800-223-9074 Fax: (302) 422-1346 TDD: (302) 424-7141~~

~~9.2 Administration~~

~~Herman M. Holloway, Sr. Campus Main Administration Building, First Floor Annex 1901 N. DuPont Highway New Castle, DE 19720 1-800-223-9074 Fax: (302) 255-4445~~