CMS-10434-OMB-0938-1188

Package Information

Package ID DE2018MS0002O

Program Name Assertive Community Integration Support Team

SPA ID DE-18-0006

Version Number 1

Submission Type Official

State DE

Region Philadelphia, PA

Package Status Pending

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility, Health Homes | DE2018MS0002O | DE-18-0006 | Assertive Community Integration Support Team

Package Header

Package ID	DE2018MS0002O	**SPA ID**	DE-18-0006
Submission Type	Official	**Initial Submission Date**	N/A
Approval Date	N/A	**Effective Date**	N/A
Superseded SPA ID	N/A		

State Information

State/Territory Name:	Delaware	**Medicaid Agency Name:**	Division of Medicaid and Medical Assistance

Submission Component

- (•) State Plan Amendment
- (•) Medicaid
- ( ) CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility, Health Homes | DE2018MS0002O | DE-18-0006 | Assertive Community Integration Support Team

Package Header

Package ID DE2018MS0002O

SPA ID DE-18-0006

Submission Type Official

Initial Submission Date N/A

Approval Date N/A

Effective Date N/A

Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID DE-18-0006

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Mandatory Eligibility Groups	10/1/2018	DE-17-0010
Optional Eligibility Groups	10/1/2018	DE-17-0010
Health Homes Intro	10/1/2018	
Health Homes Geographic Limitations	10/1/2018	
Health Homes Population and Enrollment Criteria	10/1/2018	
	10/1/2018	

~~Reviewable Unit~~	~~Proposed Effective Date~~	~~Superseded SPA ID~~
~~Health Homes Providers~~		
~~Health Homes Service Delivery Systems~~	~~10/1/2018~~	
~~Health Homes Payment Methodologies~~	~~10/1/2018~~	
~~Health Homes Services~~	~~10/1/2018~~	
~~Health Homes Monitoring, Quality Measurement and Evaluation~~	~~10/1/2018~~	

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility, Health Homes | DE2018MS0002O | DE-18-0006 | Assertive Community Integration Support Team

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Executive Summary

Summary Description Including Goals and Objectives

Delaware's ACIST (Assertive Community Integration Support Team) program supports individuals who have a Severe and Persistent Mental Illness (SPMI) and an intellectual and developmental disabilities (I/DD) or Autism using a comprehensive, holistic, multi-disciplinary team-based approach to crisis intervention, intensive case management, behavior analysis, psychiatric supports and monitoring of medical conditions. The ACIST Health Home program design uses a whole-person approach to supports and services for individuals with dual diagnosis (SPMI & I/DD) while ensuring strong integration across behavioral health, somatic health and long-term supports and services. The ACIST program is tailored to individuals with chronic conditions of SPMI and I/DD who may require additional and/or different services or modalities to ensure effective intervention. The goals of the ACIST Health Home are:

a) To lessen or eliminate critical health and safety issues that each individual member might experience, working toward preventing or mitigating these signs, symptoms, and/or social issues that

could lead to crisis situations and the need for hospitalization or re-hospitalization
b) To provide transitional support and post psychiatric hospitalization follow along that will assist the individual in ameliorating the effects of their mental health condition and dual diagnosis and prevent avoidable readmissions
c) To improve the overall medical and physical health of the individual
d) To meet basic human needs and enhance quality of life
e) To improve the person's opportunity to be successful in social and employment roles and activities
f) To increase active participation in the person's community
g) To partner with families, support systems and/or significant other in supporting the individual's recovery

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2019	$436050
Second	2020	$436050

Federal Statute / Regulation Citation

Section 1902(a) of the Social Security Act and 42 CFR 447

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility, Health Homes | DE2018MS0002O | DE-18-0006 | Assertive Community Integration Support Team

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Governor's Office Review

- (•) No comment
- ( ) Comments received
- ( ) No response within 45 days
- ( ) Other

Submission - Public Comment

MEDICAID | Medicaid State Plan | Eligibility, Health Homes | DE2018MS0002O | DE-18-0006 | Assertive Community Integration Support Team

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Superseded SPA ID	N/A		

Name of Health Homes Program

Assertive Community Integration Support Team

Indicate whether public comment was solicited with respect to this submission.

- ○ Public notice was not federally required and comment was not solicited
- ○ Public notice was not federally required, but comment was solicited
- ◉ Public notice was federally required and comment was solicited

Indicate how public comment was solicited:

- ☐ Newspaper Announcement

Name of Paper:	Date of Publication:	Locations covered:
State News	9/3/2018	Kent and Sussex Counties
The News Journal	9/3/2018	New Castle and Kent Counties

☐ Publication in state's administrative record, in accordance with the administrative procedures requirements

Date of Publication: Oct 1, 2018

☐ Email to Electronic Mailing List or Similar Mechanism

☐ Website Notice

☐ Public Hearing or Meeting

Date of meeting: 4/19/2018

Time of meeting: 9:00 AM

Location of meeting: DHSS Chapel / 1901 N. DuPont Hwy.; New Castle DE 19720

Communication Method

- Telephonic Capability Used

Public Forum Used

- The Medical Care Advisory Committee that operates in accordance with 42 CFR 431.12

☐ Other method

Upload copies of public notices and other documents used

Name	Date Created	
MCAC Minutes_April 2018 Meeting	8/23/2018 3:51 PM EDT	
MCAC Agenda_2018-04-19	8/23/2018 3:51 PM EDT	
284899-1 DHSS- Home Health	9/5/2018 12:06 PM EDT	
Public Notice Newspaper September 3 2018 (002)	9/7/2018 9:05 AM EDT	
DRR Public Notice	10/2/2018 3:23 PM EDT	

1 – 5 of 5

Upload with this application a written summary of public comments received (optional)

Name	Date Created	
Summary of Public Comment	10/2/2018 3:21 PM EDT	

Indicate the key issues raised during the public comment period (optional)

- ☐ Access
- ☐ Quality
- ☐ Cost
- ☐ Payment methodology
- ☐ Eligibility
- ☐ Benefits
- ☐ Service delivery

- [ ] ~~Other issue~~

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Eligibility, Health Homes | DE2018MS0002O | DE-18-0006 | Assertive Community Integration Support Team

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Superseded SPA ID	N/A		

Name of Health Homes Program

Assertive Community Integration Support Team

One or more Indian health programs or Urban Indian Organizations furnish health care services in this state

- ○ Yes
- ◉ No

Submission - Other Comment

MEDICAID | Medicaid State Plan | Eligibility, Health Homes | DE2018MS0002O | DE-18-0006 | Assertive Community Integration Support Team

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Superseded SPA ID	N/A		

SAMHSA Consultation

Name of Health Homes Program

Assertive Community Integration Support Team

The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Date of consultation
5/17/2018

Medicaid State Plan Eligibility

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility, Health Homes | DE2018MS0002O | DE-18-0006 | Assertive Community Integration Support Team

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Submission Type	Official	**Initial Submission Date**	N/A
Approval Date	N/A	**Effective Date**	10/1/2018
Superseded SPA ID	DE-17-0010		
	System Derived		

Mandatory Coverage

A. The state provides Medicaid to mandatory groups of individuals. The mandatory groups covered are:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Infants and Children under Age 19					CONVERTED
Parents and					CONVERTED

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Other Caretaker Relatives					
Pregnant Women					CONVERTED
Deemed Newborns					NEW
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care					NEW
Former Foster Care Children					NEW
Transitional Medical Assistance					NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Extended Medicaid due to Spousal Support Collections					NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
SSI Beneficiaries					NEW
Individuals Receiving Mandatory State Supplements					NEW
Individuals Who Are					NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Essential Spouses					
Institutionalized Individuals Continuously Eligible Since 1973					NEW
Blind or Disabled Individuals Eligible in 1973					NEW
Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972					NEW
					NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increases since April, 1977					
Disabled Widows and Widowers Ineligible for SSI due to Increase in OASDI					NEW
Disabled Widows and Widowers Ineligible for SSI					NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
due to Early Receipt of Social Security					
Working Disabled under 1619(b)					NEW
Disabled Adult Children					NEW
Qualified Medicare Beneficiaries					NEW
Qualified Disabled and Working Individuals					NEW
Specified Low Income Medicare Beneficiaries					NEW

~~Eligibility Group Name~~		~~Covered In State Plan~~	~~Include RU In Package~~	~~Included in Another Submission Package~~	~~Source Type~~
~~Qualifying Individuals~~					~~NEW~~

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility, Health Homes | DE2018MS0002O | DE-18-0006 | Assertive Community Integration Support Team

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	System-Derived		

B. The state elects the Adult Group, described at 42 C.F.R. §435.219.

◉ Yes ○ No

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Adult Group					CONVERTED

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- ~~N/A~~

Medicaid State Plan Eligibility

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility, Health Homes | DE2018MS0002O | DE-18-0006 | Assertive Community Integration Support Team

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Superseded SPA ID	DE-17-0010 System-Derived		

A. Options for Coverage

The state provides Medicaid to specified optional groups of individuals. *

◉ Yes ○ No

The optional eligibility groups covered in the state plan are (elections made in this screen may not be comprehensive during the transition period from the paper-based state plan to MACPro):

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Optional Coverage of		☐	☐	○	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Parents and Other Caretaker Relatives					
Reasonable Classifications of Individuals under Age 21					NEW
Children with Non-IV-E Adoption Assistance					CONVERTED
Independent Foster Care Adolescents					NEW
Optional Targeted Low					NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Income Children					
Individuals above 133% FPL under Age 65					APPROVED
Certain Individuals Needing Treatment for Breast or Cervical Cancer					NEW
Individuals Eligible for Family Planning Services					NEW
Individuals with Tuberculosis					NEW
					NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Electing COBRA Continuation Coverage					

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash					NEW
Individuals Eligible for Cash except for Institutio					NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
nalization					
Individuals Receiving Home and Community Based Services under Institutional Rules					NEW
Optional State Supplement Beneficiaries - 1634 States, and SSI Criteria States with 1616 Agreements					NEW
Optional State					NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Supplement Beneficiaries-209 (b) States,and SSI Criteria States without 1616 Agreements					
Institutionalized Individuals Eligible under a Special Income Level					NEW
Individuals participating in a PACE Program under Institutional Rules					NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Receiving Hospice Care					NEW
Qualified Disabled Children under Age 19					NEW
Poverty Level Aged or Disabled					NEW
Work Incentives Eligibility Group					NEW
Ticket to Work Basic Group					NEW
Ticket to Work Medical Improve					NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission on Package	Source Type
ments Group					
Family Opportunity Act Children with Disabilities					NEW
Individuals Eligible for Home and Community-Based Services					NEW
Individuals Eligible for Home and Community-Based Services - Special Income Level					NEW

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility, Health Homes | DE2018MS0002O | DE-18-0006 | Assertive Community Integration Support Team

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Superseded SPA ID	DE-17-0010 System-Derived		

B. Medically Needy Options for Coverage

The state provides Medicaid to specified groups of individuals who are medically needy. *

○ Yes ◉ No

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility, Health Homes | DE2018MS0002O | DE-18-0006 | Assertive Community Integration Support Team

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Superseded SPA ID	DE-17-0010		
	System-Derived		

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Health Homes Intro

MEDICAID | Medicaid State Plan | Eligibility, Health Homes | DE2018MS0002O | DE-18-0006 | Assertive Community Integration Support Team

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Superseded SPA ID	N/A		

Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

Assertive Community Integration Support Team

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

Delaware's ACIST (Assertive Community Integration Support Team) program supports individuals with Severe and Persistent Mental Illness (SPMI) and I/DD and/or Autism to receive a comprehensive, holistic team-based approach to crisis intervention, intensive case management, behavior analysis, psychiatric supports and monitoring of medical conditions in a multi-disciplinary model. The ACIST Health Home program is designed to provide a whole-person approach to supports and services to individuals with dual diagnosis and to ensure strong integration across behavioral health, somatic health and long-term supports and services.

~~The ACIST program is tailored to individuals with chronic conditions of SPMI and I/DD who may require additional and/or different services or modalities to ensure effective intervention. The goals of the ACIST Health Home are:~~

~~a) To lessen or eliminate critical health and safety issues, that each individual client might experience, toward preventing or mitigating these signs, symptoms, and/or social issues that could lead to crisis situations and the need for hospitalization or re-hospitalization~~

~~b) To provide post psychiatric hospitalization follow along that will assist the individual in ameliorating the effects of their mental health condition and dual diagnosis~~

~~c) To improve the overall medical and physical health of the individual~~

~~d) To meet basic human needs and enhance quality of life~~

~~e) To improve the person's opportunity to be successful in social and employment roles and activities~~

~~f) To increase active participation in the person's community~~

~~g) To partner with families and/or support systems in supporting the individual's recovery~~

~~The health home providers will be designated ACIST entities meeting rigorous provider qualifications, including demonstrated experience working with the target population. The program will operate in a fee-for-service service delivery system, utilizing a per-member-per-month payment.~~

~~General Assurances~~

- ~~The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.~~
- ~~The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.~~
- ~~The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.~~

- ~~The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.~~
- ~~The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.~~
- ~~The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.~~

Health Homes Geographic Limitations

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- (•) Health Homes services will be available statewide
- ( ) Health Homes services will be limited to the following geographic areas
- ( ) Health Homes services will be provided in a geographic phased-in approach

Health Homes Population and Enrollment Criteria

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Categories of Individuals and Populations Provided Health Homes Services

The state will make Health Homes services available to the following categories of Medicaid participants

- Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- Medically Needy Eligibility Groups

Health Homes Population and Enrollment Criteria

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Population Criteria

The state elects to offer Health Homes services to individuals with

- Two or more chronic conditions — **Specify the conditions included**
  - Mental Health Condition
  - Substance Use Disorder
  - Asthma
  - Diabetes
  - Heart Disease
  - BMI over 25
  - Other (specify)

Name	Description
Severe and Persistent Mental Illness	Severe and Persistent Mental Illness (SPMI) - "1" below must be

~~Name~~	~~Description~~
	~~met, in addition to either "2", "3", or "4":~~ ~~1. Designated Mental Illness: The individual meets the criteria in the current DSM. Has a psychiatric diagnosis other than alcohol or drug disorders, organic brain syndromes, developmental disabilities or social conditions. ICD-Coding Manual psychiatric categories and codes that do not have an equivalent in DSM are also included mental illness diagnoses.~~

~~Name~~	~~Description~~
	~~And~~ ~~2. SSI or SSDI due to Mental Illness: The individual is currently enrolled in SSI/SSDI due to a designated mental illness.~~ ~~Or~~ ~~3. Extended Impairment in Functioning due to Mental Illness: Documentation that the individual has experienced two of the following four functional limitations due to a designated mental illness over the past 12 months on a continuous or intermittent basis:~~ ~~i. Marked difficulties in self-care~~

Name	Description
	(personal hygiene, diet, and clothing, avoiding injuries, securing health care or complying with medical advice). ii. Marked restriction of activities of daily living (maintaining a residence, using transportation, day to day money management, accessing community services). iii. Marked difficulties in maintaining social functioning (establishing and maintaining social relationships, interpersonal interactions with primary

	~~Name~~	~~Description~~
		~~partner, children or other family members, friends, neighbors, social skills, compliance with social norms, appropriate use of leisure time).~~ ~~iv. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner (ability to complete tasks commonly found in work settings or in structured activities that take place in home or school settings, individuals may exhibit limitations in~~

~~Name~~	~~Description~~
	~~these areas when they repeatedly are unable to complete simple tasks within an established time period, make frequent errors in tasks, or require assistance in the completion of tasks).~~ ~~Or~~ ~~4. Reliance on Psychiatric Treatment, Rehabilitation and Supports: A documented history shows that the individual at some prior time met the threshold for 3 (above), but the symptoms and/or functioning problems are currently attenuated by medication or~~

~~Name~~	~~Description~~
	~~psychiatric rehabilitation and supports. Medication refers to psychotropic medications which may control certain primary manifestations of mental disorder; e.g. hallucinations, but may or may not affect functional limitations imposed by the mental disorder. Psychiatric rehabilitation and supports refer to highly structured and supportive settings which may greatly reduce the demands placed on the individual and thereby, minimize overt~~

~~Name~~	~~Description~~
	~~symptoms and signs of the underlying mental disorder.~~
~~Intellectual and Developmental Disability (including autism)~~	~~Requires a diagnosis of an intellectual developmental disability (including brain injury), autism spectrum disorder or Prader Willi Syndrome assigned in the developmental period and also documented functional limitations. The diagnosis of Intellectual or Developmental Disability is determined by a licensed psychologist, certified school~~

Name	Description
	psychologist or a licensed physician who practices psychiatry who certifies that the individual/applicant has significantly sub-average intellectual functioning and meets the following criteria: An adaptive behavior composite standard score of 2 or more standard deviations below the mean; or a standard score of two or more standard deviations below the mean in one or more component functioning areas (ABAS:

~~Name~~	~~Description~~
	~~Conceptual, Social; Practical: VABS: Communication; Daily living Skills, Social).~~

- ~~One chronic condition and the risk of developing another~~
- ~~One serious and persistent mental health condition~~

Health Homes Population and Enrollment Criteria

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Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home

- ○ Opt-In to Health Homes provider
- ◉ Referral and assignment to Health Homes provider with opt-out
- ○ Other (describe)

Describe the process used

Members will initially be identified via multiple streams to include but not be limited to; self-referral, community navigators, support coordinators, professionals supporting individuals in day or residential services, medical and psychiatric professionals, hospitals, and psychiatric facilities.

Reciprocal coordination will occur between Health Home and corresponding DSAMH (Division of Substance Abuse and Mental Health) services to include the DSAMH Eligibility and Enrollment Unit regarding individuals referred to either program who may be more effectively served within another program.
Enrollment will take place once

~~application is received and all relevant medical and psychiatric documentation has been reviewed to confirm the qualifying diagnoses.~~

~~Individuals will be advised of their referral to the Health Home, and will be informed of all available options for services so that they can make an informed decision as to whether they will elect to remain in or opt out of the Health Home.~~

~~Enrollment is complete upon submission of qualifying diagnoses and consent for treatment has been signed. Consent for release of information will authorize sharing of information between identified service providers, the State, applicable Managed Care Organizations (MCO's) and other fee for service providers.~~

~~The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Homes benefit or to change Health Homes providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individuals of the Health Homes benefit and their rights to choose or change Health Homes providers or to elect not to receive the benefit~~

Name	Date Created	
ACIST intro letter	4/18/2018 11:07 AM EDT	

Health Homes Providers

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Types of Health Homes Providers

- Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

- Physicians
- Clinical Practices or Clinical Group Practices
- Rural Health Clinics
- Community Health Centers
- Community Mental Health Centers
- Home Health Agencies
- Case Management Agencies

Community/Behavioral Health Agencies

Federally Qualified Health Centers (FQHC)

Other (Specify)

Provider Type	Description
Certified ACIST Health Home Providers	Certified by the Division of Developmental Disabilities as a qualified provider of Health Home Services. Certified ACIST Health Home providers meet rigorous standards of clinical and operational proficiency, including meeting specified staffing arrangements, response capabilities, fiscal accountability and solvency. Must adhere

~~Provider Type~~	~~Description~~
	~~to all standards, policies, and guidelines in the State of Delaware Program Contract including: The Contractor agrees to adhere to the requirements of DHSS Policy Memorandum # 46 (responding to reportable incidents/allegations), and Divisional procedures regarding the reporting and investigation of suspected abuse, neglect, mistreatment, misappropriation of property and significant injury of residents/clients receiving~~

~~Provider Type~~	~~Description~~
	~~services, including providing testimony at any administrative proceedings arising from such investigations.~~ ~~Contractor shall conduct child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del. Code Section 708; and 11 Del. Code, Sections 8563 and 8564. Contractor shall not employ individuals with adverse registry findings in the performance of contract.~~

~~Provider Type~~	~~Description~~
	~~The Contractor agrees that professional staff employed in the execution of this contract shall be state licensed, certified, or registered in their profession as required by state law.~~ ~~Must adhere to all standards in the Delaware's ACIST Health Home State Plan Amendment~~ ~~All ACIST providers must agree to accept the terms and conditions under the Medicaid provider contract as a~~

~~Provider Type~~	~~Description~~
	~~condition of enrollment to provide services.~~ ~~DDDS will initially and on ongoing basis certify that the Health Home provider qualifies with the Health Home Provider criteria.~~

- ~~Teams of Health Care Professionals~~
- ~~Health Teams~~

Health Homes Providers

MEDICAID | Medicaid State Plan | Eligibility, Health Homes | DE2018MS0002O | DE-18-0006 | Assertive Community Integration Support Team

Package Header

Package ID	DE2018MS0002O	**SPA ID**	DE-18-0006
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Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

Each Certified ACIST Health Home Provider must maintain the following minimum standards. ACIST services teams will be based on a 50 person program with staff to client ratio of 1:10. ACIST services will be provided statewide by the designated providers. The average numbers of full-time employees (FTEs) for each level of staff reflected for each ACIST team are below.

Position Requirements
Team Leader : 1 FTE Master's level clinician- oversees program delivery and operation

Prescriber (Psychiatrist or Psychiatric Nurse Practitioner): 1 PT @ 25 hours per week: Initial appointments 30-45 minutes; 15 minute med checks for each individual once per month; participation in daily and team meetings. Note: the prescriber is a pivotal team member assisting with crisis response, however, his/her direct services are billed through the Medicaid State Plan.

Registered Nurse (RN): 1FTE: follow up on medical and psychiatric appointments; assist prescriber with monthly appointments; attend daily

~~meetings; attend team meetings as needed.~~

~~Case Manager/Behavior Analyst (CM/BA) (Bachelor's degree or higher; background and experience writing and/or working with behavior plans.): 2 FTE coordinate psychiatric and medical appointments; educate families about Mental Health diagnosis; develop treatment plan with individual; work with individual, residential staff, families to understand reasons for interventions on the behavior plan and how to properly use interventions; participate in daily meetings and team meetings.~~

~~Master's Level Clinician: 1 FTE (can be an additional Behavior Analyst); attend daily meetings; attend team meetings; provide individual and/or family therapy two times per month (more frequently if needed); participate in the development of treatment and behavior plans;~~

~~As demonstrated above, Delaware's health home program will use a comprehensive team of medical, mental health, developmental disability, social services, and other disciplines to ensure that enrollees receive needed medical, behavioral, developmental disability supports, including community based crisis prevention and response services. These supports are either provided directly by the designated health home provider or the health home provides needed linkages to all supports and services, in accordance with the individual's overarching person-centered plan. All team members will be responsible for communication on the individual's status, treatment options, actions taken and outcomes as a result of any intervention. All members of the team are also responsible for ensuring that all care and support provided is person-centered, culturally competent and linguistically capable.~~

~~To ensure the ongoing caliber of health home services, the State will maintain a highly collaborative and coordinated working relationship with each designated provider through regular, frequent communication and feedback. The state will also provide ongoing opportunities for continuous learning and best practice identification for all health home provider entities.~~

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Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services

9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

The State provides ongoing and regular technical assistance, sufficient resources, and partnership with all elements noted above.
1. Detailed provider manuals and protocols delineating all expectations and practice guidelines;
2. Specifications for all required quality reporting;
3. Access to and training on state-specified information technology;
4. Introductions and follow up to ensure effective relationship establishment with all related provider types within the state; and,
5. Any as-needed and ad-hoc supports needed by the provider to ensure their effective execution of the Health Home

The state will provide ongoing monitoring and swift interventions to ensure continuous high quality health home services.

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Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

The state's requirements and expectations for Health Homes providers are as follows:

The following requirements apply to the provision of services for all Certified ACIST Health Home Providers:

1. Services will maintain best practice guidelines for SPMI and IDD/Autism including integration of CMS' definition of community inclusion and must adhere to all applicable requirements set forth by the State of Delaware.
2. Health Home shall have sufficient clinical, administrative and information technology infrastructure to ensure that it is capable of meeting standards.
3. The majority of services will be provided in the home and community where the individual lives rather than in an office, unless requested by the individual and substantiated in the individual record.
4. An appropriate level of supports will be provided to each individual; with frequency and duration of each contact being provided at a level specific to the individual's need as specified in the treatment plan.

5. Housing options for the individuals served must meet criteria established by the state as appropriate and meet all required licensing and certification requirements as necessary.
6. A team approach will be utilized in which all team members are familiar with the needs of each individual served by the team and are capable of providing the appropriate treatment interventions to them when called upon to do so.
7. Multiple team members will interact with each individual supported in any given day/week/month across agency and family settings.
8. The teams will have daily meetings at which time each individual's needs are reviewed and treatment strategies are delineated and treatment plans updated, as required by clinical and professional determinations in accordance with the individual's person-centered plan.
9. The teams will have responsibility for acute crisis services, by providing 24 hour coverage; with staff being available either by phone or in person, as appropriate, to help diffuse crisis situations and maintain community status. The contactor is not permitted to use automated phone trees as its answering service. The goal of 24 hour coverage is to intervene during acute crisis situations to reduce or eliminate the need for hospitalization.
10. The team will maintain an effective working relationship with the state's Division of Substance Abuse and Mental Health's Mobile Crisis Unit in order to respond to calls for individuals who are ACIST members and/or are being seen by the ACIST provider.
11. Health home provider will develop and implement a Quality Improvement Program designed to ensure services are consistently delivered to individuals in accordance with the Health Home services and in alignment with best practice guidelines. The program will also assure that services are based on a recovery model, person centered, and trauma informed. Results of QI activities will be written and submitted to the state on a monthly basis.
12. The health home provider will comply with all record reporting systems required and provided by the state including automated client record keeping system.

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Health Homes Service Delivery Systems

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Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- Fee for Service
- PCCM
- Risk Based Managed Care
- Other Service Delivery System

Health Homes Payment Methodologies

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Payment Methodology

The State's Health Homes payment methodology will contain the following features

- Fee for Service
  - Individual Rates Per Service
    - Per Member, Per Month Rates
    - Fee for Service Rates based on
      - Severity of each individual's chronic conditions
      - Capabilities of the team of health care professionals, designated provider, or health team
  - Other

Describe below

The payment will be based on the costs to operate a fully functioning ACIST team with the composition specified in the SPA.

☐ Comprehensive Methodology Included in the Plan

☐ Incentive Payment Reimbursement

Not Applicable

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

☐ PCCM (description included in Service Delivery section)

☐ Risk-Based Managed Care (description included in Service Delivery section)

☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

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Agency Rates

Describe the rates used

- (•) FFS Rates included in plan
- ( ) Comprehensive methodology included in plan
- ( ) The agency rates are set as of the following date and are effective for services provided on or after that date

Health Homes Payment Methodologies

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Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates
2. Please identify the reimbursable unit(s) of service
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
4. Please describe the state's standards and process required for service documentation, and
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
   - the frequency with which the state will review the rates, and
   - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description

1. The Delaware ACIST service will be a Per Member Per Month (PMPM) rate as allowed under the Health Home (HH) service model.

The rate includes personnel cost, occupancy, travel, administration and general, and variable costs. The data for the rate computation was taken from actual expenditures of the contracted agency for the pilot

demonstration, another agency who had bid for the pilot demonstration, and wage data from the Bureau of Labor and Statistics.

Salary models were built using FTE and salary information across benchmark data provided by:

- The contracted state-funded pilot demonstration provider;
- Another respondent to the pilot demonstration RFP; and
- Bureau of Labor and Statistics (BLS)

The staffing plan and respective FTEs for each ACIST team were initially established by DDDS in the RFP for the ACIST pilot and are also codified in the SPA. These specifications were determined to be necessary for the successful operation of the ACIST program, with considerations for expected member acuity and minimum levels of service. Salaries for all position types were compared across the three data sources. The annual salary costs used for the rate were the average of the three benchmarks with similar titles and position descriptions. The $67,650 established for Team Leader is an average of salary specified for the pilot vendor, the other bidder that was not selected and BLS classification of “Social and Community Service Managers”. The $148,860 established for Psychiatric Nurse Practitioner is an average of the pilot agency, the non-selected RFP bidder and the 90th percentile of the BLS classification of “Nurse Practitioner”. The $69,633 established for Registered Nurse is an average of the pilot agency, the non-selected vendor, and the BLS classification “Registered Nurse”. The $39,040 established for Case Manager is an average of Case Manager for the pilot agency, Case Manager for the non-selected bidder and the BLS classification “Substance Abuse, Behavioral Disorder, and Mental Health Counselors”. The $49,369 established for Licensed Clinician is an average of Licensed Clinician for the pilot agency, Master’s Prepared Clinician for the non-selected bidder and the BLS classification

~~"Mental Health and Substance Abuse Social Worker". The $225,907 established for Psychiatrist is an average of Psychiatrist for the pilot vendor, the Director of Reintegration Services for the non-selected bidder and the BLS classification of "Psychiatrist". The $31,795 established for Administrative Assistant is an average of Administrative Assistant for the pilot vendor, Administrative Assistant for the non-selected bidder and the BLS classification "Administrative Assistant". Transportation costs were calculated using different vehicle estimates as a benchmark for determining the annual cost of vans and sedans involved with necessary transportation to/from/of members for program activities. Costs for vehicles were estimated using values obtained from Kelley Blue Book for used 2016 vehicles in the Delaware area. Repair and Maintenance cost was estimated at 10% of the value of the vehicle. Insurance costs were established at $2,000 per vehicle, and due to the high need for transportation as part of this program, mileage was estimated at 15,000 miles per vehicle. In total, 4 vehicles were allocated for client transportation for each ACIST team including, three sedans and one van, for a total annual cost of $37,128.~~

~~Payroll Taxes and Fringe Benefit cost was estimated at the national average Taxes and Fringe rate of 31.70% as per BLS. The ACIST program also incorporates administration and general at 12% of direct personnel costs, upon DHSS recommendation. This is consistent with the budget proposals received from the pilot vendor and the non-selected vendor. Occupancy cost was benchmarked per FTE, at $6,281, based on the pilot vendor's occupancy costs, since they are currently the only provider and their program most closely mimics the staffing plan established by DDDS. In addition, a Discretionary Cost PMPM of $5.75 was applied to the overall PMPM rate based on the need for educational, recreational, or food supplies for members in order to facilitate~~

~~conversations and services.~~
~~2. Per member per month rate.~~
~~3. HH providers must deliver at least three (3) of the six defined core HH services within the calendar month to the eligible HH beneficiary in order to receive a PMPM that month. To receive the first PMPM payment for an eligible HH beneficiary, a HH provider must inform the HH beneficiary about available HH services, receive the beneficiary's consent to receive HH services, and begin the development of a care plan. The development of the care plan will follow standards for Comprehensive Care Management described in the SPA. This activity is tracked through the Electronic Health Record (EHR). Each of the six core services has a list of activities within that service that the Support Coordinator/Community Navigator will check on a monthly basis. HH providers will submit claims via MMIS using a designated coding for health home services. Any other State Plan Medicaid services delivered by a HH will be claimed fee for service separate and distinct from the Health Home monthly service.~~
~~4. Any claim for HH services shall be supported by written documentation in the EHR. Minimum documentation requires that HH provider document HH activity under any of the six core health home services it has delivered that month, including Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care from Inpatient to Other Settings, Individual and Family Support, or Referral to Community and Social Support Services. . Documentation must include the service, frequency, duration and actions taken by the HH staff and the response of the recipient and any progress towards stated outcome(s). Documentation will be reviewed within the EHR by the assigned Support Coordinator/Community Navigator on a monthly basis. All claims for health home services will be~~

~~subject to regular audits to ensure that Medicaid payments made to HH providers are consistent with efficiency, economy and quality of care, and made in accordance with federal and state conditions of payment.~~

~~5. Rates will be considered for rebasing after each fiscal year, with a minimum of a rebased rate every three years.~~

~~a. During annual rate reviews, the State will assess utilization levels and quality improvement metrics to determine the quality of services and the need for rate adjustments. b. Factors such as cost of living and cost inputs from additional ACIST providers and teams will also be considered.~~

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Assurances

The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved	Delaware will ensure non-duplication between Health Home benefits and State Plan and Medicaid HCBS services through person-centered planning practices. All underlying state plan benefits including those available to a child through EPSDT will be billed separately and directly by appropriate provider. In addition, individuals receiving health home benefits who are also enrolled in Delaware's HCBS Lifespan Waiver (CMS Control Number DE0009) will be ineligible to also receive the included HCBS waiver services of behavior analysis and nurse consultation. Individuals receiving health home benefits may not receive services through the Delaware Promise program as authorized through the state's approved 1115 demonstration program except to the extent that those services are over and above that which is available under the ACIST program.

- The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).
- The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.
- The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
No items available		

Health Homes Services

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Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition

Comprehensive Care Management (CCM) in ACIST Health Homes will include the development of a treatment plan for areas impacted by the individual's mental health condition, consistent with the individual's DDDS person centered plan, for service provision based upon a comprehensive history and ongoing monitoring of:

i. Psychiatric history, status, and previous diagnosis
ii. IDD/Autism functional assessment
iii. Individual outcomes as stated by the individual
iv. Housing and living situation
v. Vocational, educational, and social interests and capacities
vi. Self-care abilities
vii. Family and social relationships
viii. Family education and support needs
ix. Physical health
x. Alcohol and drug use
xi. Legal situation
xii. Personal and environmental resources

Assessments will be completed within 30 days of admission. Individual goals, psychiatric evaluation and treatment will be reevaluated every 6 months. Treatment plans should also be re-evaluated any time a client experiences a significant life-event (e.g. hospitalization, death of a close friend or family member, significant changes in medications, etc.). Treatment plans will be strength-based, person-centered and will reflect individual preferences and key personal objectives. The plans will reflect a trauma-informed approach to supports.

CCM will also ensure the implementation of the treatment plan, including the seamless coordination of all health home functions and facilitating any necessary linkages to supports and services necessary for its effective implementation.

For individuals in ACIST Health Homes also receiving 1915(c) Lifespan Waiver services, the treatment plan will be incorporated into the individuals' person-centered Life Span plan, and the health home team will be an integral partner in the shaping and delivery of services to ensure seamless integration across the spectrum of supports available to the individuals served.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

ACIST Health Home providers will utilize electronic health records as required by the State of Delaware, enabling the integration of key health, social, and behavioral health data for all health home members. Treatment plan and related data metrics will be incorporated into this platform.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses

- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

Provider Type	Description
Certified ACIST Health Home Provider	This HH component can be completed by any ACIST team member as most appropriate for the individual's symptom presentation but will be developed utilizing protocols established and monitored by the team leader.

Care Coordination

Definition

Care Coordination is the implementation of the treatment plan with active member involvement through appropriate linkages, referrals, coordination, and follow-up to needed services and supports. Care coordination is designed to be delivered in a flexible manner best suited to the individual and family's preferences and to support goals that have been identified by developing linkages and skills in order to allow health home members to reach their full potential and increase their independence in obtaining and accessing services.

Care coordination duties include, but are not limited to:

Coordinating with all team members to ensure all objectives of the comprehensive, treatment are progressing;

Scheduling and communicating appointment times, including arranging transportation and support if necessary;

Conducting referrals, facilitating linkages, and following up;

Monitoring; and

Participating in hospital discharge processes and communicating with members/family enrollees and other providers, including, as applicable, DSHP Plus LTSS case management and service providers.

Health Home services shall not duplicate services available to individuals under the Medicaid State Plan. For individuals receiving LTSS, Delaware will institute strategies through the comprehensive planning process to ensure no duplication of comparable benefits.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

ACIST Health Home providers will utilize electronic health records as required by the State of Delaware, enabling the integration of key health, social, and behavioral health data for all health home members.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists

- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

Provider Type	Description
Certified ACIST Health Home Provider	Certified ACIST Health Home Provider Bachelor's level care manager within the team followed by his/her direct supervisor.

Health Promotion

Definition

Health promotion services include
- Encouraging and supporting health education for the member/family/support persons
- Coaching members/family/support persons about chronic conditions and ways to manage health conditions based on the member's preferences
- Connecting the member to self-care programs to help increase their understanding of their conditions and care plan
- Promoting engagement of the member and family/support persons in self-management and decision making
- Encouraging and facilitating routine preventive care such as flu shots and cancer screenings
- Linking the member to resources for smoking cessation management of member chronic conditions; self-help recovery resources; and other services based on member needs and preferences
- Assessing the member's and family/support persons' understanding of the member's health condition and motivation to engage in self-management

Health promotion may include the following elements:
- Mental health symptom management and mediation
- Individual counseling and/or behavior analysis as indicated in the individual's treatment plan
- Medication, monitoring, education and documentation
- Addiction treatment and education including counseling, relapse prevention, harm reduction,
- Anger and stress management, if appropriate

Health Home services shall not duplicate services available to individuals under the Medicaid State Plan. For individuals receiving LTSS, Delaware will institute strategies through the comprehensive planning process to ensure no duplication of comparable benefits.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

ACIST Health Home providers will utilize electronic health records as required by the State of Delaware, enabling the integration of key health, social, and behavioral health data for all health home members.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers

- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

Provider Type	Description
Certified ACIST Health Home Provider	Certified ACIST Health Home Provider All members of the team may participate in health promotion services for each individual. For service components requiring clinical skillsets, the appropriate team member will carry out and/or oversee those specific elements.

Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

The health home team will maintain continued contact with individuals during inpatient or other setting stays to help insure greater continuity of service both within the facility and upon discharge from the facility. Plans for transition back to community-based settings, including necessary clinical support throughout transition, will be initiated immediately upon admission in partnership with facility discharge planners and any providers of LTSS. The team of the individual hospitalized must meet with the client multiple times per week during acute admissions throughout their inpatient stay and have periodic planning sessions with the client's treatment team/treating medical professionals. ACIST team receives all relevant discharge information and facilitates all necessary appointments and/or coordination of services pursuant to those instructions.

At a minimum, the HH will:

• utilize hospitalization or emergency department episodes to locate and engage members in need of HH services;
• perform the required continuity of care coordination between inpatient and outpatient care, including establishment or reestablishment of community resources and necessary follow-up visits; and
• engage in proactive steps to avoid readmission (including work with the individual and his/her family and analysis of antecedent activities to interrupt patterns of inpatient utilization)

HHs will have a clear protocol for responding to alerts from hospitals or any other inpatient facility to facilitate collaboration in treatment, discharge, and safe transitional care. Services as part of beneficiary contacts during transitions include but are not limited to:
a) Assisting in the development of discharge strategies;
b) Performing medication reconciliation;
c) Ensuring that follow-up appointments are scheduled and coordinated;
d) Assessing the patient's risk status tor readmission to the hospital or other failure to obtain community-based care;
e) Arranging for follow-up care management, as applicable and
f) Planning appropriate care/place to stay post-discharge, including linkages to temporary or permanent housing and arranging transportation as needed.

Health Home services shall not duplicate services available to individuals under the Medicaid State Plan. For individuals receiving LTSS, Delaware will institute strategies through the comprehensive planning process to ensure no duplication of comparable benefits.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

ACIST Health Home providers will utilize electronic health records as required by the State of Delaware, enabling the integration of key health, social, and behavioral health data for all health home members.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner

- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

Provider Type	Description
Certified ACIST Health Home Provider	Certified ACIST Health Home Provider Lead staff on the team to be determined by inpatient circumstances

Individual and Family Support (which includes authorized representatives)

Definition

Individual and family support services include activities that ensure that the HH member and family/support persons are knowledgeable about the member's conditions with the overall goal of improving their adherence to treatment and medication management. Individual and family support services also involve identifying supports needed for the member and family/support persons to manage the member's condition and assisting them to access these support services.

The member and family/support persons may be assisted through e-mails, texts, phone calls, letters, and in-person. Skills training in activities related to self-care and daily life management including utilization of public transportation, maintenance of living environment, money management, meal preparation, locating and maintaining a home, skills in landlord/tenant negotiations and renter's rights and responsibilities to the degree the individual is able to participate. In addition, Individual and Family Support Services may include:

a. Social skills training and rehabilitation necessary for functioning in a work, educational, volunteer, leisure or other community environment.
b. Employment/supported employment will be encouraged and supported for all individuals being supported by the team
c. Education, support, and consultation to individuals' families and other major supports
d. For those persons with a representative payee, the team will work with the person served and the representative payee to insure that the individual's financial needs are met, coordinated and monitored. In addition, the team will work with the individual as well as the payee to reach the goal of financial independence; however that is defined for the individual based on his/her needs and financial skills.

Health Home services shall not duplicate services available to individuals under the Medicaid State Plan. For individuals receiving LTSS, Delaware will institute strategies through the comprehensive planning process to ensure no duplication of comparable benefits.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

ACIST Health Home providers will utilize electronic health records as required by the State of Delaware, enabling the integration of key health, social, and behavioral health data for all health home members.

Scope of service

The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists
- ☐ Nurse Practitioner

- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

Provider Type	Description
Certified ACIST Health Home Provider	Certified ACIST Health Home Provider All members of the team may participate in individual and family support services for each individual. For service components requiring clinical skill sets, the appropriate team member will carry out and/or oversee those specific elements.

Referral to Community and Social Support Services

Definition

Referral to community and social support services involves determining appropriate services to meet the needs of members, identifying and

referring members to available community resources, and following up with members. Referral and linkage or direct assistance to ensure that individuals obtain the basic necessities of daily life including medical, social, financial supports. Communication and information will meet health literacy standards, trauma informed care standards, and be culturally appropriate.

Community and social support services may include, but are not limited to:

• Identifying the member's community and social support needs.

• Identifying resources and eligibility criteria for housing, food security and nutrition, employment counseling, child care, community-based LTSS, school and faith-based services, and disability services, as needed and desired by the member, and referring members as appropriate.

• Identifying or developing a comprehensive individually-tailored resource guide for the member

• Actively managing appropriate referrals to the needed resources, access to care, and engagement with other community and social supports

• Following up with the member to ensure needed services are obtained

• Coordinating services and follow-up post engagement

• Checking with member routinely to ensure they are accessing the social services they require

Health Home services shall not duplicate services available to individuals under the Medicaid State Plan. For individuals receiving LTSS, Delaware will institute strategies through the comprehensive planning process to ensure no duplication of comparable benefits.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

ACIST Health Home providers will utilize electronic health records as required by the State of Delaware, enabling the integration of key health, social, and behavioral health data for all health home members.

Scope of service

The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists
- ☐ Nurse Practitioner

- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

Provider Type	Description
Certified ACIST Health Home Provider	Certified ACIST Health Home Provider Bachelor's level care manager within the team followed by his/her direct supervisor.

Health Homes Services

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Package ID	DE2018MS0002O	**SPA ID**	DE-18-0006
Submission Type	Official	**Initial Submission Date**	N/A
Approval Date	N/A	**Effective Date**	10/1/2018
Superseded SPA ID	N/A		

Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

Referral source will complete a Brief Screen for Eligibility followed by an application for ACIST Services.
Brief Screen will be reviewed by Division of Developmental Disabilities Services Crisis Care Coordinator for eligibility. Referral will be directed to equivalent DSAMH Services when appropriate and/or individual does not meet ACIST Criteria.
ACIST Application, eligibility, insurance coverage, consent for treatment, consent to release information and assurances will be reviewed by Developmental Disabilities Services Crisis Care Coordinator for completion and forwarded to chosen Health Home Provider

Name	Date Created	
DE ACIST Health Home Patient Flow	4/10/2018 2:00 PM EDT	

Health Homes Monitoring, Quality Measurement and Evaluation

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Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates

Delaware will calculate and monitor cost savings through a number of mechanisms. For individuals with an established Medicaid claim history, cost savings data will be calculated by comparing current year with historical costs for individuals. For individuals without established claims history, the state will determine a projected service utilization trajectory using data from individuals with similar presentation and symptoms to ascertain the cost avoidance achieved through the health home intervention. In addition, Delaware will include an analysis of individual outcomes to demonstrate the value provided through the health homes (employment, housing stability, etc).

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless

patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider)

The State will require that participating health homes providers use an operational Electronic Health Record (EHR) system to support the delivery of health home services. This EHR will be prescribed by the state and will include individual health statistics, service utilization, risk assessments, and comprehensive person-centered plan information. The EHR enables data sharing (with appropriate permissions) among the individual, the providers supporting him/her, and the state to ensure a comprehensive, whole-person record of support. The system will include critical health information including pharmacology to ensure complete integration of physical health, behavioral health and long -term services and supports. The system will also include information on what is important to the individual in addition to what is important for the individual, ensuring that supports and services and undertaken with an understanding of personal preferences.

This system will enable real time access to data to inform linkages to needed social supports and other determinants of health. It will foster and further seamless transitions when individuals experience inpatient encounters, and will ensure full team access to all necessary information.

Health Homes Monitoring, Quality Measurement and Evaluation

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Quality Measurement and Evaluation

- The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state
- The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals
- The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS
- The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report

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